

**GAY MEN, LESBIANS,  
AND THEIR ALCOHOL AND OTHER DRUG USE:  
A REVIEW OF THE LITERATURE  
VOLUME II**

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## SECTION 1

### INTRODUCTION

Prevention specialists increasingly argue that more attention needs to be directed toward populations at risk of developing high prevalence rates of heavy or problematic alcohol and other drug (AOD) use. This is viewed as a more cost effective use of limited resources for reducing overall AOD problems in this country. Furthermore, prevention and intervention efforts targeted at the general population have not been found effective in dealing with special populations at high risk. Identifying and studying such populations is thus important for the allocation of scarce resources as well as designing effective prevention and intervention (e.g., treatment) programs.

Gay men and lesbians, who comprise an estimated 6 percent to 10 percent of the US population (Bell and Weinberg 1978), have long been identified by clinicians and practitioners as at high risk of AOD abuse and related problems. Indeed, Ziebold and Mongeon (1982:5-6) characterize alcoholism and addiction among sexual minorities as a *"devastating public health problem...calling for intensive prevention efforts."* That most gays and lesbians *"survive and lead useful lives"* without succumbing to this problem is, they assert, *"testimony to their extraordinary strengths."* Nevertheless, considerable uncertainty surrounds the prevalence, patterns, and correlates of use within this population. There has been a pronounced lack of research on AOD use among sexual minorities. None of the few broadly based studies of gay and lesbian populations have systematically assessed AOD abuse (e.g., Bell and Weinberg 1978; Shagir and Robins 1973); few AOD studies have been conducted specifically on sexual minorities; and sexual orientation has been almost totally ignored as a correlate of use among general population AOD studies.



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Over the course of the 1980s, the situation has improved somewhat, in large part because of advocacy within the gay and lesbian movements and concerns over the connection between AOD use and HIV disease. Nevertheless, there are still large gaps in our knowledge. The research that has been conducted has focused far more on gay men than lesbians, and on alcohol than other drugs. Much of it also is of limited value because of methodological problems in sample selection and size (Nardi 1982; Stall and Wiley 1988). Accurately determining the prevalence of AOD use and related problems among sexual minorities is complicated because much of this population is "hidden" throughout the general community and hence not easily identifiable for study or survey (Israelstam and Lambert 1989:55). Nardi (1982a:9) stresses the difficulty faced in research in this area as follows: *"Alcoholism [or other drug addiction] is difficult enough to define, and finding a cross-section of homosexuals (both open gays as well as those still repressed) is unrealistic."* Because of this difficulty, most of the discussion of AOD abuse within this community is based on clinical reports, or limited or biased studies, especially due to inadequate sampling (McKirnan and Peterson 1989:546). Much of the early data was derived from small, unrepresentative samples of hospitalized or imprisoned populations.

While studies in the 1970s broadened their perspective into the gay and lesbian community, most still consisted of small convenience samples, mostly of bar patrons. Bars provide unequalled access to samples because they are one of the few settings in which sexual minorities assemble publicly. However, although bar patrons certainly are the most visible gays and lesbians, they may not be an accurate representation of the general gay and lesbian population. The number and representativeness of gays and lesbians who indulge in a bar-centered lifestyle is not documented (Israelstam and Lambert 1989:56). Even among heterosexuals, bar patrons contain a proportion of heavy drinkers far outweighing that of the general populace and may also include more than their share of drug users (Clark 1981). Several research studies conducted since the mid-1980s have tried to



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overcome these sampling biases, but the problems of studying this "hidden" population still presents a formidable challenge.

This review summarizes the current state of knowledge about: (1) the prevalence and patterns of use among gays and lesbians; (2) correlates of use or factors that place at high risk of abuse or related problems as well as protective factors which may ameliorate other risk factors; (3) the relationship between AOD use and risk of HIV infection; and (4) prevention and intervention. As much as possible, we have differentiated the data between alcohol and other drugs and between gays and lesbians. Although there are similarities in use of both licit and illicit substances, it is important to discern how the use of specific drugs relates to risk of developing AOD-related problems. Equally, although lesbians and gays have a great deal in common, differences between them may have significant prevention and intervention implications.



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## SECTION 2

### USE PREVALENCE

In this section, the literature in regard to the prevalence and levels of AOD use in general is reviewed as it relates first to gay men and then to lesbians.

#### 2.1 GAY MEN

##### 2.1.1 Alcohol

Until the mid-1980s, almost all the research on AOD use among sexual minorities was focused on alcohol and found prevalence rates of abuse or problem drinking consistently in excess of those generated for general population samples. More recent research using broader samples has confirmed high levels of use and related problems in regard to alcohol, but has raised questions about whether these levels are as high as previously believed.

The most frequently cited estimate of the percentage of gay men with drinking problems is 30 percent, three times higher than estimated rates in the general population. This statistic dates back to studies conducted in the mid-1970s using divergent sampling and measurement techniques within very different gay communities, but all of which had limitations, particularly the use of nonrepresentative convenience samples. In probably the most frequently cited study, Fifield and colleagues (Fifield 1975; Fifield, Latham and Philips 1977) estimated that approximately one third of the adult gay and lesbian population in Los Angeles County repeatedly abused alcohol to problem drinking proportions based on a convenience sample consisting of 200 gay and lesbian bar patrons at 98 (out of 300) bars, 53 recovered alcoholics in treatment programs, and 132 users of the Gay Community Services Center.

Lohrenz et al. (1978) reported that nearly one third of gay men were alcoholic based on an opportunistic mail survey employing the Michigan Alcoholism Screening Test of 145



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gay men (out of 460 questionnaires distributed) in a bar sample in two Kansas university towns and two cities.

Finally, from another non-representative sample of 89 gay men identified largely from homophile organizations, Saghir and Robins (1973) found that 30 percent reported that they were excessive or dependent drinkers at some point in their lives, compared with 20 percent of 35 single heterosexual men in a control group (see also Saghir et al. 1970a).

Considerable skepticism surrounds these high estimates, in part because of the sampling biases. Recent studies using more broad-based samples have produced more inconsistent results. Among 266 San Francisco gay men in an opportunistic sample, Morales and Graves (1983) found daily use rates of 12 percent for beer, 9 percent for spirits, and 8 percent for wine. Out of seven community problems, they listed alcohol abuse as number four. The sample was identified through community groups and centers and through personal networks.

McKirnan and Peterson (1989) studied a diverse cross-sectional sample of 2603 gay men and 748 lesbians (total 3,400, largely white) in urban Chicago who returned mail-in surveys distributed throughout the community, primarily through distribution among 21,000 readers of a gay newspaper (a 16 percent return rate). They found substantially higher proportions had tried alcohol than had been reported in the general population. However, contrary to other reports, this was not accompanied by higher rates of heavy use (over 60 drinks per month), although gay men and lesbians did show higher rates of alcohol problems. Taken as a whole, the proportion of gays and lesbians who were abstainers was about half that in the general population (14% vs. 29%). Significantly, the lower number of abstainers did not translate into a higher proportion of heavy drinkers (15% vs. 14%), but both gays and, particularly, lesbians reported higher rates of alcohol problems. It appears that the difference was not related to the effects of consumption levels -- alcohol problems related to the same levels of consumption in both populations -- so much as age factors and, to a lesser extent, gender differences. Among males, there were no significant differences in



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level of use between gay and heterosexual respondents, but 23 percent of gays reported alcohol problems vs. 16 percent of heterosexuals. Young gay and heterosexual males showed similar problem rates. Although symptoms declined in both samples and sexes over age 30, gay males over this age reported markedly more symptoms with far less of a decrease than the general population.

To overcome the sampling limitations of previous research, Stall and Wiley (1988) studied AOD use in 1984 among a large random household sample of 1,034 single urban gay and heterosexual men (age 25-54) as part of the San Francisco Men's Health Study. All the men lived in the 19 census tracts of San Francisco where the AIDS epidemic has been concentrated. This study is significant in that it compared single gays with single heterosexuals rather than all males in the general population. The authors found even less evidence to support exceptionally high rates of alcohol use and abuse than McKirnan and Peterson. Although gay men were almost twice as likely to be frequent/heavy drinkers (at least once a week) as heterosexuals (19% vs. 11%), this was considerably less than previously estimated: the 30 percent alcoholism figure overestimates by 63 percent the rate generated for frequent/heavy drinking (not just alcoholism or problem drinking). Furthermore, contrary to previous reports, the distribution of alcohol consumption among gay and heterosexual men as a whole (e.g., their drinking habits) was not significantly different. The majority of both groups fell in the frequent/light category (59 percent of gays and 65 percent of heterosexuals) and gay men were approximately twice as likely to be abstainers as heterosexuals (5.7% vs. 2.5%). When maximum alcohol consumption during the previous 12 months was examined, controlling for age, there was a slightly higher probability of heterosexual men drinking at the heavy maximum consumption levels: 54 percent of heterosexuals drank a minimum of seven drinks on a single occasion at least once during the previous six months, compared with 48 percent of gays. At the highest levels of frequent use, proportional differences were minimal.



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As a whole, the data implies that whatever differences in drinking may exist between gay and heterosexual males appears to occur at the extreme patterns of use; that is, abstinence and heavy use. However, even the rate of heavy drinking falls within the general range of rates found in general population surveys in San Francisco. This implies that extreme differences in prevalence rates of alcoholism and/or problem drinking between heterosexual and gay men probably do not exist. The authors conclude that although frequent/heavy drinking is *"fairly common within this population and may constitute a behavioral risk to the health of a sizeable segment of the gay male community,"* but the prevalence of heavy drinking *"is not exceptionally high"* (p. 70). The higher rates that were reported appear to be related to age factors, as found by McKirnan and Peterson. Whereas the prevalence of drinking frequently declined by nearly one-third among heterosexuals from the youngest to oldest cohort, among gay men the oldest cohort drank more like younger gay men than heterosexuals their own age.

Martin (1990) found considerable consistency in the typical alcohol consumption patterns from a sample of self-identified gay men in New York City over a four-year period. Drinkers consumed an average of 5 drinks per week. In 1986, 12 percent of the sample met the DIS/DSM-III diagnostic criteria for alcohol abuse and/or dependence; in 1987, the rate fell to 9 percent. Based on this and the Stall and Wiley (1988) study, Martin concluded that *"problem drinkers are not typical of gay men, and are unlikely to constitute as much as a third of the homosexual population."*

### **2.1.2 Other Drugs**

It is even more difficult to make precise statements regarding use of drugs other than alcohol among gay men because fewer studies have been conducted. Survey reports did not begin appearing until the 1980s. Higher use prevalence rates of several illicit drugs, especially of nitrite inhalants, have been reported among gays compared to the general male population, but differences in regard to heavy use and related problems for most drugs are not clear.



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Morales and Graves (1983) reported that, over the prior twelve months, three-quarters (76%) of their San Francisco gay male sample used marijuana, half used cocaine (53%) or nitrites (58%). Around a fifth to a quarter reported use of methamphetamine, quaaludes, and MDA. The most popular drug for daily use was marijuana (14%). About 2 percent reported daily use of cocaine, methamphetamine, and other stimulants, as well as nitrite inhalants ("poppers"). In addition it was estimated that 18 percent were at risk of serious AOD-related problems, and the sample related drug abuse as more problematic than alcoholism, ranking it third out of seven problems (alcoholism was fourth), with only AIDS and homophobic attacks preceding it.

In Stall and Wiley's (1988) San Francisco Men's Health Study, the gay men were more likely than the single heterosexuals to use several specific drugs and a greater variety over the six-month period prior to the survey. But differences in the frequent use of these drugs were comparatively minor. The most pronounced difference occurred in the rates of use of poppers (58% vs. 1%), followed by MDA (9% vs. 2%), barbiturates (25% vs. 9%), and amphetamines (28% vs. 17%). Less significantly higher use was also reported for marijuana (78% vs. 71%) and psychedelics (18% vs. 12%). In addition, gay men were more than seven as times likely to have used five or more drugs; and to be nine times more likely to do so if they were under age 35. This high rate of use of a variety of drugs raises the possibility that concurrent (polydrug) use of two or more drugs is relatively common, especially as almost all the population used alcohol. This suggests that gay men should be considered at relatively high risk for serious morbidity and even mortality due to drug interactions or overdoses. However, the data could not confirm this thesis.

On the other hand, proportionate differences in the use of marijuana, cocaine, psychedelics, and the opiates were not large. Furthermore, gay men did not differ significantly from heterosexuals in the frequency of use of most drugs (as was the case with alcohol), the exceptions being poppers, barbiturates, and amphetamines. The differences that did exist in user prevalence, variety of drugs used, and frequency of use were largely the



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habits of the youngest cohort of gay men, those under age 35. Among men over the age 35, relatively few differences emerged. Whether the relationship between age and use was the result of a cohort or an aging (maturational) effect could not be determined. Thus, the authors conclude, gays probably are best characterized as at "exceptionally high prevalence rates of drug use," but whether they are similarly at risk for problematic use "remains open" (p. 71).

In their community survey, McKirnan and Peterson (1989) found trends for illicit drug use and problems similar to those they found for alcohol: lower rates of abstinence but only slightly higher rates of heavy use based on a comparison general population survey. The gay and lesbian community as a whole reported significantly lower rates of abstention than heterosexuals. Comparing gay and heterosexual males, contrary to the findings of Stall and Wiley (1988), proportionally higher use was reported among the older age group than younger. Although use declined with age in both samples, gay men (and the total gay/lesbian sample) reported far less of a decrement in drug use across age groups than did the general population: lifetime marijuana use rates were 79 percent vs. 68 percent for gays and heterosexuals, respectively, between ages 18 and 25; 83 percent vs. 65 percent for ages 26-34; and 67 percent vs. 17 percent for those age 35 or over. Differences in lifetime cocaine use were even greater between gay and heterosexual males: 52 percent vs. 35 percent, respectively, for those age 18-25; 56 percent vs. 26 percent for age 26-34; and 26 percent vs. seven percent for 35 and older.

As reported by Stall and Wiley (1988), there were more modest differences in frequent/heavy use among gay men, but contrary to Stall and Wiley, these again reflected higher levels of use among older age gays than heterosexuals, not among younger. Frequent marijuana use (defined as use during 10 of the past 30 days) was reported by 16 percent of gays compared to 23 percent of heterosexuals aged 18-25, and 16 percent vs. 11 percent, respectively, among those aged 26-34, and 8 percent vs. 2 percent for those aged 35. Rates for frequent cocaine use (use in 5 of past 30 days) showed a similar pattern, with



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comparable rates of use among those aged 18-25 (3.3% vs. 2.7%, respectively) and noticeably higher rates of use among gay men aged 26-34 (3.7% vs .8%, respectively). Among men age 35 and over, frequent cocaine use was negligible in both groups. Use of poppers again emerged as a distinctive gay male problem: 14 percent used them at least occasionally to weekly and another seven percent used frequently to daily, whereas use is negligible in the general population. (Unfortunately, the authors did not examine rates of drug-related problems.)

Among 298 gay male clients at a Boston health center studied in a two-year longitudinal study by McCusker et al. (1990), lifetime prevalence rates were the following: 59 percent for marijuana, 52 percent for nitrite inhalants, 37 percent for cocaine, 7 percent for amphetamines, and 2 percent for barbiturates, LSD, and methaqualone. Among those who used drugs throughout the two years of the survey, initial monthly use was 82 percent for marijuana, 69 percent for nitrite inhalants, and 53 percent for cocaine. All these rates were higher than lifetime rates for the sample as a whole.

#### *IV Drug Use*

Considerable attention has been directed at IV drug use due to its role in the etiology of HIV disease. It is surprising, therefore, how little information is available about the prevalence of intravenous (IV) drug use among gay men. Most studies have focused the characteristics and behaviors of gay IV drug users (as discussed below). But the evidence would indicate that the IV drug user (IVDU) represents a relatively small minority of the gay population. In the San Francisco Men's Health study, they constituted eight percent of the total sample of gay/bisexual men. Generally, they were white, younger than forty, graduated from high school but not from college, and may have initiated sexual intercourse with other males at a relatively early age, and engaged in high-risk drug use and sexual behavior (Stall and Ostrow 1989). McCusker et al. (1990) found a lifetime rate of only one percent for IV heroin use among their gay health center clients.



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### ***Nitrite Inhalant Use***

Nitrite inhalants appear to be a distinctive drug among gay males. The bulk of the literature indicates that volatile nitrite use had saturated the gay male population by 1974 and since 1978, they have indulged in them more than any other group. In some samples, the use of volatile nitrites by gay men has approached 100 percent (Israelstam et al. 1978; Marmor et al. 1982). The studies reviewed above (i.e., Morales and Graves 1983; McCusker et al. 1990; McKirnan and Peterson 1989; Stall and Wiley 1989) indicate a lifetime and current prevalence rate well over 50 percent and high rates of frequent use. Use of nitrites is especially common in combination with other drugs. Goode and Troiden (1979) found regular nitrite users especially more likely to be frequently intoxicated from alcohol (see also Spada 1979).

The most recent and extensive investigation of this pattern of use is by Robert Lange and colleagues. In a study of 80 males in Washington DC and Baltimore by Lange, Haertzen, and Hickey (1988), 21 percent reported nitrite inhalant use in the 6 months before interview; 47 percent of these used them in conjunction with other recreational drugs, most commonly with marijuana. Of the gay males, 20 were interviewed while participating in a gay support group; 60 in gay bars. Lange et al. (1988) compared this data with that derived from a sample of IVDUs in treatment from six regions of the United States, one of which was Baltimore. The findings indicate that nitrite use is more extensive among gay males than IVDU. Among gays, 69 percent admitted to every having used nitrite inhalants, with no demographic differences between users and nonusers, with mean age of onset at 22 years. Of users, 78 percent had used only amyl nitrite, contrary to expectations that its use had been replaced by butyl nitrite. Again, multiple drug use emerged as the predominant pattern. Almost half (47%) used them concomitantly with one or more other drugs, almost universally with marijuana.

This use pattern is especially problematic because of its association with HIV disease, as discussed below. But use appeared to be declining. The mean period since peak use was



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4.1 years. The current level of use was 21 percent, the same as observed in heavy drug users in the same locale (22%). The authors speculate this decline is due to fear of an association with HIV infection. A similar decline was not apparent among IVDUs.

### ***Speed Use***

Data also indicates that, at least in some locales, speed use may be especially prominent in the gay community. Newmeyer (1988:185) reports on data that indicated 4.5 percent of gays in San Francisco used speed on at least a weekly basis in the prior six months. Treatment data from the Haight Ashbury Free Medical Clinic indicated that 60 percent of speed users are gay men.

## **2.2 LESBIANS**

Not surprisingly, given the relative lack of studies on AOD use among women until recently, there is a paucity of research on lesbians, although there is a considerable body of clinical discussion. Further complicating research, lesbians generally maintain lower profiles than gay men (Israelstam and Lambert 1989:58). Discussions of the problem have multiplied over the past decades, but representative surveys with heterosexual comparisons are still few in number and most still deal with alcohol. In the general population, women consume substantially less than men, but estimates of alcoholism among lesbians have exceeded those for heterosexual men. Recent research indicates that prior estimates of alcoholism among lesbians have been exaggerated but, nevertheless, AOD use among them far exceeds that of heterosexual women and is more similar to their male gay peers.

### **2.2.1 Alcohol**

Estimates for alcoholism among women in general range between 5 percent to 8 percent (Fillmore 1984), whereas rates of 20 percent to 35 percent have been cited for lesbians. Indeed, as Anderson and Henderson (1985) noted, there is "*considerable agreement in the literature that lesbians are more likely to experience alcohol problems than*



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*are heterosexual women or than either hetero- or homosexual men."* However, such conclusions are again based on only a few studies, most using clinical, incarcerated, or otherwise biased samples. Population-based probability studies have yet to be conducted (Paul, Bloomfield, and Stall. Forthcoming)

For example, among 40 lesbians and matched heterosexual controls who were patients at an outpatient psychiatric clinic, Swanson et al. (1972) reported that four times as many lesbians were habituated to alcohol, amphetamines, or barbiturates.

In a sample of 57 lesbians drawn from ranks of homophilic organizations and 43 demographically matched heterosexual women, Saghir and Robins (1973) reported that lesbians had higher rates of alcoholism than either heterosexual women or men or even gay men, although lesbians and gay men were most similar. Over a third (35%) of lesbians described their drinking behavior as excessive or alcohol dependent at some point in their lives, versus 5 percent of heterosexual female controls, 20 percent of heterosexual males, and 30 percent of gay males. Thus homosexual women had rates of excessive and problem drinking more comparable to homosexual men and heterosexual men than to heterosexual women (see also Saghir et al. 1970b). Analyzing the same data with a modified criteria for alcoholism, Lewis, Shagir, and Robins (1982) reported similar rates: 33 percent of the lesbians exhibited heavy drinking or questionable alcoholism versus 7 percent of heterosexual female controls. Furthermore, 28 percent of lesbians, but only 5 percent of controls, described their drinking behavior as alcoholic at some point in their life. These results, however, are probably not representative because of the small sample size (although it was the largest to date) and its recruitment from homophilic organizationS (Glaus 1989).

Fifield and colleagues (Fifield 1975; Fifield, DeCrescenza, and Latham 1975; Fifield, Latham, and Phillips 1988) estimated a 30 percent prevalence rate for alcoholism among lesbians in their bar sample. But, as noted, this convenience bar sample was not representative and no heterosexual comparison group was used. Furthermore, no effort was made to determine differences between gays and lesbians.



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Two studies examined lesbians as part of larger general population AOD use surveys. In a study of ghetto drinking patterns, Sterne and Pittman (1972) found that among 28 black lesbian residents of a housing project, 29 percent were definitely heavy drinkers, but no controls were used. Milman and Su (1973) reported lesbian behavior was positively correlated with heavy alcohol and marijuana use among undergraduates women at a mid-Atlantic university in 1969, 3 percent of whom admitted engaging in "*homosexual behavior*." However, since many heterosexuals engage in same-sex acts, the lesbian sample in this study was probably overly inclusive (Mosbacher 1988).

Among the 129 lesbians in Morales and Graves (1983) opportunistic San Francisco survey (28 percent of the total sample), alcohol consumption prevalence rates were only 4 percent to 10 percent lower for beer, wine and spirits than among gay males. However, lesbians had a higher proportion of daily beer drinkers (16%) than gays. Furthermore, alcohol use was identified by them as the second most important problem facing the community, whereas it was fourth among gay males.

A survey of treatment clients indicated that same-sex orientation was greater among female and male alcoholics (Mills and Nelson 1982). But treatment samples may not accurately reflect the prevalence of use among the population in general.

Thus, those studies indicating that lesbians are at appreciably greater risk of alcohol abuse than heterosexual women were fairly seriously flawed (Mosbacher 1988:49). Recent studies with more general populations have cast doubt on the 30 percent prevalence rates, but nevertheless indicate there exists an extensive problem with alcohol within the lesbian community. McKirnan and Peterson's (1989) study of sexual minorities in Chicago included 748 lesbians (22 percent of the total sample) and was the "most rigorous" effort yet attempted to determine alcohol and alcohol-related problem prevalence in the lesbian community (Paul, Bloomfield, and Stall. Forthcoming). The significant gender differences in alcohol use found in the general population of females were not as evident among lesbians. Overall prevalence rates were higher: 15 percent of lesbians were abstainers,



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versus 34 percent of women in the comparison general population survey. But there were not significant differences in rates of heavy use: 9 percent of lesbians were heavy drinkers, versus 7 percent in the general population. Compared with gays (above), lesbians reported more similar rates of abstention and proportions of moderate and heavy use than is the case in the general population, where there are more pronounced gender differences, although overall lesbians reported significantly lower average consumption than did gays.

Similarly, although general population men and women differ markedly in alcohol problem rates, gays and lesbians did not. Rates of alcohol-related problems (23%) were noticeably lower than estimates from earlier research, but still higher than general population estimates of 8 percent. Furthermore, whereas younger gay males (under age 30) did not differ in problem rates in the two samples, younger lesbian women did differ markedly from their heterosexual counterparts. Among females, rates were 24 percent vs. 16 percent for age 18-25; 23 percent vs. 7 percent for age 26-30; and 25 percent vs. 8 percent for age 31-40. Gay males over age 30 reported substantially higher problem rates than evident in the general population. Indeed, the higher problems reported by lesbians accounted for much of the overall higher rate reported by the total gay and lesbians population compared to heterosexuals.

One study of one specific subgroup -- 42 female medical professionals -- Mosbacher (1986) reported that alcohol abuse was equally prevalent among lesbians and heterosexual women in the sample. Eighteen percent of the lesbians, 18 percent of the heterosexuals, and 13 percent of the bisexuals answered "yes" to questions highly associated with alcohol abuse. These findings are limited in value by the small sample size, its nonrepresentativeness, and use of nonspecific definitions of sexual orientation. But they do support other findings indicating that alcohol abuse outside of clinical, bar, and other convenience samples may be far less prevalent than previously believed.



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## 2.2.2 Other Drugs

Research on use of drugs other than alcohol among lesbians has been virtually nonexistent. While there are considerable gender differences in drug use between males and females in the general population, this is less the case between gay males and lesbians. It appears that lesbians engage in higher rates of illicit drug use and patterns of mixed AOD use than the general population of females, but the exact prevalence is largely unknown (Glaus 1989:132).

Swanson et al. (1972) observed in their sample of patients that four times as many lesbians as heterosexual women were habituated to amphetamines and barbiturates. Diamond and Wilsnack (1978) found that 60 percent of their sample of 10 alcoholics mixed alcohol with marijuana and 60 percent mixed alcohol with amphetamines, hallucinogens, and barbiturates.

The lesbians surveyed by Morales and Graves (1983) reported a lower proportion of use of all illicit drugs in the past 12 months than did gay men, but rates for marijuana were only 6 percent lower than among gay men (70% vs. 76%) and rates were higher for cocaine (54% vs. 52%) and quaaludes (29% vs. 26%). The greatest differences between lesbians and gays were for nitrites (58% vs. 11%), MDA (22% vs. 9%), and methamphetamines (21% vs. 12%). Whereas they listed alcohol abuse as the second greatest problem facing the community, they ranked drugs only fifth out of seven. Thus, whereas gay males considered drug abuse a more serious problem than alcohol, women considered alcohol abuse more serious. Twice as many also reported an increase in use than gay males (14% vs. 7%). Of 10 related adverse experiences, more lesbians than gay males reported having had nine of them (the exception being arrested for possession or sales). It was estimated that 25 percent of them had problematic drug use, compared with 18 percent of gay males. They were less frequent users of a variety of drugs, but still were multiple drug users. However, these differences could be due to the different demographic characteristics of the female/male samples.



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This section presents an analysis of the data gathered from this survey. All data were analyzed separately for men and women; within these two categories, the data were further separated into lesbian and bisexual women, and gay and bisexual men.

The data are organized as follows:

- Profile of survey respondents
- Alcohol and other drug use patterns and risk levels
- Alcohol and drug related problems
- Context, setting, and purpose for higher risk users
- Help seeking behavior

### 3.1. PROFILE OF SURVEY RESPONDENTS

If generalizations can be made about all survey respondents, it appears that they were primarily white, well-educated, employed, and with firmly established gay, lesbian or bisexual identities. Of the 748 respondents, 44 percent (327) were women. Seventy-seven percent were white, and 87 percent reported having at least some college education. (A surprising 31 percent reported post-college educations.) Seventy-three percent were employed, and 26 percent reported being full or part-time students. Average age for the entire set of respondents was 34.

Over half (54%) reported belonging to at least one gay or lesbian organization. Three-quarters said they had self-identified as lesbian or gay for six or more years. Most lived alone or with roommates (35 percent for each), with 23 percent reporting living with a lover. Thirty-seven percent indicated that they were in a primary relationship with a lover at the current time.

Of the 327 female respondents, 240, or 74 percent, identified themselves as lesbians. One respondent identified himself as male, lesbian and transsexual. Twenty-four percent of all women described themselves as bisexual. Among the 421 male respondents, 382 (84%) identified themselves as gay, and 35 (8%) as bisexual. Ten people said they were heterosexual, and these respondents' data were not used in the analysis.



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very high rates of lifetime alcohol (36%) and other drug use (48%), but low rates of current abuse.

As discussed further below, all these studies examined the issue of the association between AOD use and HIV infection. It would appear that concerns over this association are a primary but not exclusive reason for this decline in use. It also appears connected with the general shift to healthier lifestyles within the gay and lesbian communities in general. Similarly, concerns over health and changing lifestyles have led to a reduction in alcohol consumption, especially spirits, among adults in the general population in general. The interest in body building and physical fitness is one trend that has been identified as discouraging heavy AOD use (Israelstam and Lambert 1989:64).

Hasting (1982) has speculated that alcohol use was (or would be) declining among lesbians for a variety of reasons. These included (1) the effects of the women's movement, which helped to create alternative meeting places to the lesbian bar and more opportunities for lesbians in mainstream society; (2) the spread of treatment facilities and self-help groups that specialize in helping lesbians and the growing presence of recovering lesbian alcoholics who served as role models and influenced a shift in attitudes; and (3) sociocultural changes that have made it easier to be open about one's sexual preference today. As a result, attitudes towards drinking have become more critical in the lesbian community and abstinence from alcohol is now seen as a "*symbol of the serious person*," which is admired (in contrast to the male bar-going culture). However, she provides no evidence to support this, nor is there any in the other literature reviewed and, as discussed below, others (e.g., Smith and Balcer 1983) have not documented any attitude change.

Commonly given explanations for this decline given by gay men surveyed by Remien et al. (1990) included non-HIV related health problems, changes in other risky behaviors that lead to a reduction in alcohol/drug use, and a generalized change in norms within the gay community regarding substance use. Delaying onset of clinical AIDS symptoms was a commonly mentioned reason among HIV seropositive gay men. Few identified treatment



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as an important factor, a finding that is undoubtedly related to low treatment utilization and satisfaction rates, as discussed below. This suggests that factors involving "maturation" or "spontaneous remission" may have played as important a role as concerns over HIV infection (Paul, Bloomfield, and Stall. Forthcoming).

## 2.4 DISCUSSION

Although early studies found AOD use, abuse, and problems to be exceptionally higher among sexual minorities compared to heterosexuals, most of these studies were flawed, especially by sampling bias. More recent, broadly-based surveys have reported use prevalence rates higher than in the general population, but evidence regarding levels of heavy and problem use is more inconclusive. The gay and lesbian community is at high risk of AOD abuse, but the degree of difference between them and the general population clearly requires further investigation. Multiple drug use among young gay males and alcohol abuse among lesbians would particularly warrant attention.

Regarding alcohol, neither of the two major recent studies by Stall and McKirnan and their colleagues found rates approaching the long-quoted 30 percent alcoholism rates. Indeed, McKirnan found no significant differences in heavy use between the gay and lesbian community and heterosexuals. On the other hand, whereas Stall found no extreme differences in rates of problem drinking McKirnan found higher rates of dependency-loss of control problems. Differences appear greater between lesbians and heterosexual women than between gay and heterosexual men: lesbians generally were much more similar to gay men in their AOD use than to women in the general population (i.e., there are less pronounced gender differences).

Regarding other drugs, it is difficult to draw any firm conclusions on the basis of the limited data available, but it appears that both gay men and lesbians become more involved in the use of some specific drugs than the general population and that they tend to use a greater variety of drugs. It is not evident that they are significantly more heavy consumers



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of the most popular recreational drugs. The most consistent finding is the exceptionally high rates of nitrite inhalant use among gay men, for reasons discussed below. Again, gender differences were more pronounced among heterosexuals than sexual minorities.

#### **2.4.1 Age Factors**

The findings further point out the importance of studying different age categories and the need to devote more attention to older gays and lesbians, among whom there is less of a decline in alcohol use over time than occurs among heterosexuals. Differences in use among those over age 34 clearly warrant further attention as Stall found few use differences between older gay and heterosexual males whereas McKirnan did.

In this regard, although young males are clearly the population most at risk, we know very little about adolescent gays and lesbians. Research is specially needed concerning sexual orientation and AOD use among runaway youth, many of whom become involved in homosexual acts even if they do not self-identify themselves as sexual minorities. Youth forced to living on the streets experience more severe drug problems than students, and many become involved with homosexual acts for survival. The Larkin Street Youth Center in San Francisco reported that more than 75 percent of their clients identified as gay had serious and chronic disorders. The Los Angeles Suicide Prevention Center found a strong correlation between substance abuse and suicide attempts among gay young people (USDHHS 1989:3-129).

#### **2.4.2 Ethnicity**

Another major gap in our knowledge is differences among ethnic groups. Recent studies have largely ignored ethnic subgroups, and only a few discussions have been published (e.g., Icard and Traustein 1987; NIDA 1989; Sandoval 1977). Reflecting this problem, similar to general AA demographics, gay and lesbian AA members are primarily white and middle-class (Paul, Bloomfield, and Stall. Forthcoming).



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Clearly, far more research is needed if we are to accurately determine the prevalence of AOD use, abuse, and related problems among gays and, particularly, lesbians. In regard to alcohol, information is especially needed on patterns of drinking (beverage preference, drinking styles, number of drinks per occasion) (Israelstam and Lambert 1989:63). Well-controlled studies with larger and more representative nonclinical samples of sexual minorities are much needed. Another problem is the lack of adequate heterosexual controls. Although samples of sexual minorities have become more representative, in most cases the findings are compared with data derived from other general population studies rather than an experimental control group.



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## SECTION 3

### CORRELATES OF USE

Not surprising, given the limits of the research on prevalence of use, there is very little definitive information about the etiology of use and abuse among sexual minorities -- about why gays and lesbians abuse alcohol and other drugs, and the similarities and differences in this process compared to heterosexuals. What are the major risk factors and correlates of use within this population? Speculations and discussions are common; empirical research studies, few. Again, most of the research has been conducted on alcohol and gay men rather than on other drugs and lesbians. However, a number of studies deal with substance abuse in general and it would appear that many of the same factors influencing alcohol use affect other drugs as well, including the potential role of the bar subculture because illicit drugs are often readily available within this culture. Therefore, in this section we will discuss etiological factors in general, noting as relevant how they have been associated with specific drugs.

Perceptions concerning why sexual minorities abuse alcohol and other drugs have changed considerably over the past two decades. Since the 1960s, empirical studies of nonclinical populations have disputed the once dominant psychoanalytically oriented hypothesis that alcoholism derived from overt or latent homosexuality (Nardi 1983:14; Israelstam and Lambert 1983). External social factors are now looked at in conjunction with inner psychological ones (Israelstam and Lambert 1989:65). Nevertheless, less than a decade ago Nardi (1982a) observed that although causal relationships between alcoholism and homosexuality have not been affirmatively established, myths still surround this area, heightened by the psychoanalytic perspective that latent homosexuality is a cause of alcoholism. Considerable confusion and inconsistency still exists in regard to specific



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etiological or risk factors, with a variety of reasons offered for their susceptibility. Before preceding to an examination of research findings, we will first review some of the major theoretical perspectives.

### **3.1 THEORETICAL PERSPECTIVES**

Generally, involvement with alcohol is seen more as a consequence of environmental or internal conflicts. Contrary to the psychoanalytic framework, same-sex orientation is not viewed as the problem but rather the individual's nonacceptance of sexual orientation, effective "coping," or societal discrimination, as well as high levels of availability and acceptance of use. The following are some of the specific reasons offered as to the high prevalence of alcohol drinking and drinking problems among sexual minorities.

#### **3.1.1 Gay Bar Ethnotheory**

Discussions of alcohol abuse within the gay and lesbian community almost universally emphasize the role of the high proportion of social or recreational settings that involve alcohol use, especially bars (Ziebold and Mongeon 1982; Glaus 1988; Nardi 1982; Nicoloff and Stiglitz 1987; Weathers 1976). In this "gay bar ethnotheory," gays and lesbians consume high levels of alcohol not because of anxiety, low self esteem, or escapism but the acquired habit of drinking in bars where they can be sexually open or, in other words, that "gay bars are often the only, or main, place where gays can meet other gays" (Kus 1988:26). Ziebold and Mongeon (1982:5) refer to the bar as "a seductive institution" for homosexuals. Habitual clients of gay bars have been characterized as "extremely hedonistic" (Sandoval 1977).

#### **3.1.2 "Hedonism"**

Expanding on the bar theory, it also has been argued that the gay culture is prone to hedonism, or at least has fewer restraints on alcohol use, including higher tolerance of



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heavy drinking, than exists among heterosexuals. This tolerance of AOD use may account for the higher levels of problems among gays and lesbians than among heterosexuals who consume similar levels of use. As Israelstam and Lamber (1989:64) observe regarding alcohol:

*As there are fewer social or individual restraints or censures regarding drinking on gays than on heterosexuals, heavy drinking is less likely to be seen as a social or psychological problem in early years and may mean that problems connected with drinking will instead manifest themselves as physical symptoms later in life.*

### **3.1.3 Stress**

A third set of theories emphasize the importance of the stress factors which gay men experience in a homophobic society. These theories (e.g., Nardi 1982; Ziebold 1978; Moses and Hawkins 1982; Gay Council on Drinking Behavior 1982) hold that internalized homophobia (self-hatred, shame, etc.), oppression, and hiding one's identify (isolation, anxiety, etc.) are as important as gay bars or hedonism in understanding the etiology and incidence of AOD use. High alcohol use is variously seen as a coping mechanism or escapism for oppression, for high levels of denial and secrecy, and for isolation and alienation (Glaus 1988; McNally 1989). In this line, Fifield's (1975) seminal study was titled, "Lonely, Isolated, and Drunk," and in it alcoholism was called the "oppression sickness." Particularly in times of distress, gays and lesbians who are alienated from their families or keep their sexual preference a secret may be more likely than heterosexuals to turn to escapist AOD use (Israelstam and Lambert 1989:61).

Ziebold and Mongeon (1982) observe that gay alcoholics at the outset of recovery are fearful and uncertain as to how they relate not only to the heterosexual world but also to the gay world. They identify four aspects of the reality of being homosexual that alcoholics do not manage well: (1) living in a hostile society; (2) having the option of "passing" for heterosexual; (3) fulfilling homosexually oriented intimacy needs; and (4) feeling worthwhile without the benefit of meeting society's expectations of being spouses or parents.



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### 3.1.4 Internalized Homophobia

A specific form of stress that is frequently cited is difficulty associated with an individual's nonacceptance of sexual identity, the inability to accept homosexuality as a positive identity, including internalized homophobia (Colcher 1982; McNally 1989; Schilit, Clark and Shallenberger 1988). For example, Israelstam and Lambert (1989:56) observe that many who are uncomfortable with their sexuality may use alcohol to help ignore their preference, or "*blank out the memory and mask the guilt of their thoughts and actions.*" Schaefer, Evans, and Coleman (1987) argue that as individuals come to grips with sexual identity issues, they often face a tremendous amount of fear, guilt, shame, and alienation, resulting in extreme psychological vulnerability that places them at high risk for AOD abuse as coping or escapist mechanisms.

This may be especially a problem for adolescents. The age of onset of drug and, especially, alcohol use has been lowering; in 1985, it was estimated to be 11.9 years for boys and 12.7 for girls. This coincides with the age that many youth are becoming aware of a gay or lesbian orientation. As the US Department of Health and Human Services (1989:3-113) notes:

*Substance use often begins in early adolescence when youth first experience conflicts around their sexual orientation. It initially serves the functional purposes of (1) reducing the pain and anxiety of external conflicts and (2) reducing the internal inhibitions of homosexual feelings and behavior.*

Coming out also usually happens at a time when one is entering young adulthood -- a peak period for AOD use. This points to the importance of examining different age cohorts of homosexuals. The relationship of feelings about sexual identity and AOD use within the adolescent population in general remains largely unexplored.

Kus (1988) argues that gay bars in no way account for either the etiology of alcoholism in gay men nor the high incidence of alcoholism in the gay community. Rather, they can only be explained by the dynamics of the coming out process, specifically, in the



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stages of the process preceding acceptance of gayness as a positive aspect of self. This theory recognizes the social oppression emphasized in the stress theories, yet holds that it is the internalized homophobia prior to having reached the stage of acceptance in the coming out process which is the root of alcoholism in gay men.

### **3.1.5 Disinhibition and Sexual Activity**

Related to the stress-reduction expectancy factor, high levels of alcohol use are also said to exist because of the drug's disinhibiting effects, especially during sexual activity. These disinhibiting effects may probably be more due to the socially determined expectancy than to pharmacologic or physiologic actions. As discussed further below in the section on AIDS, alcohol may be used by drinkers to *"deny or suspend their knowledge of sexual risks"* (McCusker et al. 1990:735, quotation from Reinarman and Critchlow 1987).

### **3.1.6 External Homophobia**

One factor that may further help explain why alcohol-related problems appear to be higher among sexual minorities than among heterosexuals who consume similar amounts (e.g., McKirnan and Peterson 1989) is that they avoid mental health and treatment programs because of the double stigma attached to their sexual orientation and AOD abuse and because the programs are viewed as insensitive to gays and lesbians. This exacerbates their problems (Ziebold and Mongeon 1982:5). The lack of treatment, and perhaps concerns over having a mental problem, have been identified as contributing to the continuation or even increase of heavy drinking among lesbians (Smith and Balcer 1983). This is discussed further in the section on prevention and intervention. (On homophobia and treatment, see also Dixon 1986, and DeCrescenzo and McGill 1978.)



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### 3.1.7 Discussion

None of these theories are, of course, mutually exclusive. In point of fact, like the heterosexual world, many different factors probably contribute to alcohol as well as other drug abuse among gays and lesbians, with the specific influences varying among individuals and circumstances. As Nardi (1982:19) observes, gay men and lesbians are a diverse group and searching for a single etiology to explain all drinking by them or to explain all forms of alcoholism *"is a misguided task."*

Nardi (1982:23) took such a multifactorial approach, emphasizing the positive aspects of alcohol use and the bar plays in becoming a member of the gay subculture, and suggesting that learning theory models emphasizing the role of *"socialization into a hedonistic, positively reinforcing life-style revolving around bars and other alcohol-oriented social functions"* may best contribute to understanding why some of those people openly gay and involved in a gay subculture may become alcoholic. The learning model stresses tension-reduction and more positive hedonistic aspects of the open gay life. The tension, anxiety, and guilt feelings that gays and lesbians experience are reduced by increased alcohol use and compounded by the role of gay bars (Nardi 1982:18).

Down playing the role of bars, Weinberg (1986) believes that the primary cause for alcoholism is that alcohol use is ubiquitous in the gay world, affecting couples as well as single men. Although love relationships appear to reduce bar attendance, they do not necessarily affect alcohol consumption. Drinking may be encouraged through participation in a close circle of couple associates, through adoption of an elegant lifestyle, by involvement with an older, more sophisticated lover or with a partner who is a bartender. In addition, stresses and strains in a relationship, often the result of unclear role definitions and consequent power and equality issues, may increase drinking. Reductions in alcohol use were often the result of feeling secure in the relationship. Drinking, which is often encouraged, or at least not discouraged in the gay subculture, may lead to the dissolution of a couple.



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Although most of these theories were developed to explain alcohol use, they also appear to apply to other drug use as well, although it is difficult to draw any conclusions because of the lack of etiological research on other drug abuse. In the following sections, we will first review the research on gays and sexual minorities in general, and then specifically on lesbians.

### 3.2 GAY MEN

Israelstam and Lambert (1989), based on their observations of patrons in over 100 gay bars in Northern America over twelve years, argue that bar patrons demonstrate a much broader range of characteristics than the stereotypic hedonistic-oriented, shallow clientele described in much of the literature (e.g., Sandoval 1977). However, many gays, male and female, tend to have fewer restraints which might normally prevent heavy drinking "*or even indicate that a person has a problem.*" Among them, levels of use that could lead to problems are more likely to go unnoticed until they are more problematic. Those gays who are most at risk are probably those at the extreme end who have no dependents or community attachments, work sporadically, spend a great deal of time in the bar lifestyle, and generally associate with others like themselves. However, they emphasize, there are others who are not interested in this scene at all (p. 56). Unfortunately, "*the proportion of gays who indulge in a lifestyle where the pursuit of pleasure through the use of alcohol and drugs is central has not been documented,*" nor the proportion who participate "after hours" and the number who are fully immersed in the lifestyle (p. 64).

Jones, Latham, and Jenner (1980) found that over 65 percent of their sample felt that being gay or dealing with their gay feelings contributed to their alcoholism (Paul, Bloomfield, and Stall. Forthcoming).

In one of the few studies to actually test a clinically-derived theory, McKirnan and Peterson (1988) tested a "stress-vulnerability" model that specific attitudes or expectancies about drugs make people vulnerable to their use to cope with stress, using their Chicago



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sample of 2,603 gay males. It was hypothesized that those who experienced more negative affectivity or discrimination and who have a strong reliance on bars as a social resource were at particular risk for substance abuse. The results confirmed the hypothesis. Tension reduction expectancies had a substantial effect on alcohol and marijuana/drug abuse, as did the use of bars as a social resource. Two stress variables -- negative affectivity and discrimination attributable to sexual orientation -- also had significant, though more moderate effects. Interactions of the vulnerability measures with the stress variables had significant effects on substance abuse beyond the main effects, supporting the central hypothesis. Contrary to Fifield (1975), McKirnan and Peterson (1989) did not find the homosexuals in their relatively broad sample to be conspicuously socially isolated or marginal.

McKirnan and Peterson (1989a) again examined whether gay men and lesbians may be at risk for AOD abuse due to psychosocial variables such as drinking styles, stress, or the cultural importance of bars in their large sample of 3,400 within a major homosexual community. Among males, greater AOD involvement was significantly but weakly related to the degree people were "out" (therefore accepting a "deviant" identity) and the less involved in traditional social roles (e.g., employment, stable relationships, religious affiliation, residential stability). Tension reduction expectancies of alcohol effects had substantial effects on AOD abuse. AOD use was also related to involvement in lifestyles in which there is a high proportion of social or recreational settings that involved alcohol and other drugs (e.g., use of bars as a social resource). About 23 percent of gay men reported that they used alcohol "half of the time" or more when coping with personal stress, and about 10 percent so used other drugs. This 10 percent figure was considered very high given the lower percentage of the general population that consistently use drugs for any reasons. Further, stress affected AOD problems only among people who were "vulnerable" via expectancies and values, thus supporting the stress-vulnerability perspective.

Kus (1988) studied the role of gay bars and nonacceptance of gay self in the etiology



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of alcoholism among 20 recovering gay men in Seattle, Iowa City, Chicago and Oklahoma City. Each of the men had been sober at least a year. All began drinking alcohol abusively before attending gay bars for the first time, and 90 percent reported that they drank abusively from their first drink. It was concluded that gay bars were totally unrelated to the disease etiology of the informants, contrary to the belief of most of the respondents themselves. Before they were sober, none of the men viewed being gay as a positive thing (i.e., all admitted nonacceptance of gayness while drinking). Yet many did not realize until they were sober that they were nonaccepting. Contrary to expectations, sobriety preceded acceptance of gayness in a positive way, rather than the other way around. Only after choosing and living sobriety did the men accept being gay as a positive aspect of self. Kus concludes that the etiology and high incidence of alcoholism among American gay men may be explained by nonacceptance of being gay as a positive aspect rather than the bar culture.

Stress also emerged as an important factor in a study of substance abuse among homosexual and heterosexual men living illegally in the United States, as well as homosexuals living in Mexico (n=21), one of the few dealing with ethnic populations. Tori (1989) found a very similar personality structure in regard to AOD use in all groups. Rorschach findings indicated that the homosexuals were experiencing dysphoric mood and distorted perceptions; they were also having significant difficulties coping with an environment that was discerned as increasingly dangerous.

### **3.2.1 Sexual Activity**

The association between AOD use and sexual activity was especially prominent. For example, in an early national mail survey of 1,038 members (primarily white) of homophile organizations, 42.8 percent used at least one drug during sex (Spader 1979). Research on this correlate of use has increased markedly because of the spread of HIV. Stall and Ostrow (1989), analyzing data from the San Francisco Men's Health Study, found that approximately three-fourths (n=543) of the entire sample had occasion to combine sexual behavior with



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some form of AOD use during the six months previous to the first wave of data collection. Stall et al. (1986) studied AOD use during sexual activity in a sample of sexually active gay men (n=655) in San Francisco (151 men identified through bathhouses; 134 from bars; 181 who did not attend bars or baths to make sexual contact; and 189 couples). Almost as many men reported sometimes or often drinking alcohol while having sex in the prior month than reported never or rarely doing so (225 vs. 238, respectively). Alcohol was the most frequently used drug during sex, followed by marijuana and poppers. This association is discussed more fully in the section below on HIV disease.

In regards to the specific high level of use of nitrite inhalants among gay men, this is clearly related to their use to facilitate receptive anal intercourse. They are used primarily during sexual activity because they reduce social and sexual inhibitions, heighten sexual arousal, relax the anal sphincter, and are thought to prolong orgasm (Haverkos and Dougherty 1988:9, 11). In addition, they are a source of euphorogenic rush and a general recreational drug as well (and more widespread) in overt sexual activity because of its purported attributes such as prolongation of penile erection and relaxation of rectal smooth muscle and anal sphincter tone, thus facilitating intromission, and general intensification or prolongation of sexual experience (Israelstam et al. 1978; Lange et al. 1988:86-87). In Washington DC and Baltimore, Lange, Haertzen, and Hickey (1988) found that only 23 percent of nitrite inhalant use was not associated with sexual activity. However, the finding that both substance abusers and gay men used nitrite inhalants primarily to get high was an "unexpected finding."

### **3.3 LESBIANS**

Many of the same factors associated with AOD use among gay men have also been associated with lesbians. For example, Kristi (1975) argues that lesbians are trapped by a subculture that encourages drinking. O'Donnell et al. (1980) feel that for lesbians gay bars are the only environment where they can be themselves. Weathers (1980) related lesbian



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alcoholism to the combination of overt societal oppression with resulting low self-esteem, anxiety, and other psychological dysfunction, and the lesbian bar as a central institution and lack of alcohol-free alternatives. Indeed, much of what is said is derived from the inaccurate assumption that gay males and lesbians are alike (Mills and Nelson 1982:444). Determining specific factors is difficult because of the lack of research. As Anderson and Henderson (1985:520) observe, *"The literature is replete with speculation about factors that may account for the high incidence of alcoholism among lesbians, but empirical research remains almost nonexistent."* It is evident, however, that in addition to similarities, there are important differences in degree and kind in the risk factors that affect lesbians compared to gays.

### 3.3.1 Stress Factors

In some respects, lesbians may face greater stress-related risks than gay men. They face the triple stigma of being alcoholic, gay, and female. Israelstam and Lambert (1989:56-57) further speculate: *"Females who hide their sexual preference do not have the same opportunities for anonymous sex, nor perhaps do they want them. They may, therefore, drink to cope with the fact that they are not satisfying sexual, affectional, or self-actualizing needs."* However, there is no research on this issue.

Saghir and Robins (1973) found that female homosexuals and their heterosexual controls had comparable prevalences of active and lifetime psychiatric disorders and of personality characteristics such as low self-esteem, inability to express anger, and inner tension. Although the lesbians showed a significantly higher prevalence of psychiatric disorders overall, there was no statistically significant difference in the prevalence of any single disorder with the exception of higher rates of alcoholism and heavy drinking, use of nonprescription drugs, and suicide attempts. The authors concluded that *"the majority of the [lesbians] were able to achieve, adapt, and be productive citizens."* Similarly, Mills and Nelson (1982:444) concluded a literature review with the observation that *"despite the large number of lesbians in treatment for drug dependence, lesbians do not appear to have a higher incidence of depression, attempted suicide, or suicide than do heterosexual women."*



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Sahir and Robins (1973) did observe higher levels of alcohol problems among those in conflict over their sexual orientation than those who accepted it, suggesting that coming out or the development of a positive lesbian self-identity may be an issue for many chemically dependent lesbians (Glaus 1989:134). In McKirnan and Peterson's (1989) study, about 13 percent of lesbians (compared with 23 percent of gays) reported that they used alcohol "half of the time" or more when coping with personal stress; there were no gender differences for stress-related drug use (about 10 percent of both sexes).

### **3.3.2 Gender Identification**

It has been speculated that higher rates of alcohol use among lesbians than heterosexual women could be related to the former's adoption of more "masculine" traits. Diamond and Wilsnack (1978) reported on the basis of only ten case studies that alcoholic lesbians drank to feel verbally, sexually, and physically assertive in response to a desire to overcome feelings of dependency, which, they suggest, lesbians do not accept as readily as heterosexual women. The behavioral changes reported with drinking were predominantly in the traditional masculine direction (e.g., greater aggressiveness, activity, dominance), suggesting that they might be using alcohol in an instrumental way to reduce sex-role conflict, with the most valued self-image being more masculine. Other factors included bar attendance, social oppression, and the lesbian subculture's encouragement or at least toleration of heavier levels of drinking (i.e., drinking and drunkenness are considered normal rather than deviant behavior).

Saghir and Robins (1973) also reported that female homosexuals had significantly more masculine traits than controls. However, Lewis, Saghir, and Robins (1982) found that gender identity variables (psychosexual orientation, ambivalent gender identification) among homosexual women, did not distinguish the social drinkers from the nonsocial drinkers.



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*The lesbian social drinkers were no less homosexually oriented and no more heterosexually oriented than the lesbian nonsocial drinkers. Thus, the possibility that female homosexuals may consume more alcohol because of their more masculine attitude was not supported by the data. Although homosexual orientation and behavior was apparent long before the onset of heavy drinking, only a small minority (17%) of the lesbians subjects felt that their sexual orientation contributed to their drinking behavior." (p. 279)*

### **3.3.3 Bar Culture**

Bar culture seems to play a less central role in the etiology of alcoholism and drug use among lesbians than gay men, possibly because there are far fewer lesbian bars than male gay bars. Lewis, Saghir, and Robins (1982) further found that heterosexual women appeared to have the same exposure to alcohol at private parties and "dating" bars as lesbians. Heavy drinking among lesbians was evident even with "bar going" controlled for. Almost half (49%) of lesbians who did not frequent gay bars drank more heavily than the heterosexual women and had drinking histories similar to lesbians who did frequent these establishments. It also has been noted that many lesbians may indulge in excessive solitary drinking, especially early in the coming-out process (Glaus 1989:133).

In contrast, in a factor-analytic study comparing the use of bars, drinking patterns, and levels of alienation among alcoholic and nonalcoholic lesbians and heterosexual women, Burke (1982) found support for the etiological importance of the lesbian bar. Lesbians and heterosexual women did not differ in drinking patterns, reasons for drinking, or the importance of bars as a place to drink. Lesbians, however, tended to stay at bars longer, drink more while there, and use the bar as a place to socialize to a greater degree than heterosexual women. Lesbians also exhibited greater levels of alienation, isolation, and powerlessness, experiences which might explain the popularity of bars. Thus this study suggests that the high prevalence of alcoholism in this community may be related to the function of bars as a place to socialize in the context of high levels of alienation and isolation.



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### **3.3.4 Age Factors**

Lewis, Saghir, and Robins (1982) concluded that higher prevalence rates among lesbians compared to heterosexual women may be due to an earlier age of onset of alcoholism, which would falsely elevate prevalence rates. Fifield (1975) also discovered that lesbians entered treatment at younger age than heterosexual women.

### **3.3.5 Role Modeling**

Related to age factors, Smith and Balcer (1983) argue that younger lesbians lack AOD-free role models and often idolize older, "wiser" and often alcoholic lesbians and attempt to emulate them (p. 3).

### **3.3.6 Family Background (Children of Alcoholics)**

Several studies suggest a larger than expected proportion of the lesbian community may be children of alcoholic parents. A quarter of the lesbians studied by Saghir and Robins (1973) had at least one alcoholic parent as compared with only 9 percent of heterosexuals. Diamond and Wilsnack (1978) found that 50 percent of lesbians who were problem drinkers had relatives who were problem drinkers or alcoholics, and Swanson et al. (1972) observed that twice as many (16% vs. 7%) lesbian patients had alcoholic or abusive fathers compared to heterosexual patients (Glaus 1989:132-133). In addition, Schilit, Clark, and Shallenberger (1988), comparing 15 lesbian alcoholics and 15 lesbian nonalcoholics, could detect little evidence that the alcoholic lesbians' current support systems were as disrupted as anticipated. However, lesbian alcoholics often reported having had a less supportive childhood and adolescence, feeling unloved and unwanted.

## **3.4 CONCLUSIONS**

A review of the literature thus provides support for aspects of many etiological theories. As has been noted for the general population, the origins of AOD abuse among



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gays and lesbians is undoubtedly multifactorial, with the risk any individual faces contingent upon the quantity of risk factors that person experiences. Little can be concluded with certainty about specific factors, but it does appear that the specific role of gay bars in the etiology of alcohol abuse and problems has been over-emphasized, especially among lesbians, and that situational stresses play an important role. Among gay males, the association between substance use and sexual activity has major implications in light of the risks this poses for HIV infection, as discussed below.

Among lesbians, there is little evidence that higher rates of drinking are due to significant personality differences, including greater male orientation, than for heterosexual women, but high levels of stress that are part of being a lesbian as well as toleration of drinking within the population may play important roles. More uncertainty surrounds the importance of bars. The greater gender differences observed is no doubt related to the inconsistency in traditional sex-role expectations of women with both AOD use and the frequenting of bars (McKirnan and Peterson 1989a). The role of family alcoholism also warrants further investigation. It may well be that the overriding cause of higher levels of drinking among lesbian compared to heterosexual women is that the former simply lack the constraints that have traditionally limited drinking among women. As their evidence indicated that gay men, heterosexual men, and lesbian women had comparable rates of excessive and problem drinking, Lewis, Saghir, and Robins (1982) suggest *"that environmental factors selectively protect heterosexual women from pathologic drinking habits."*

It should be observed again that the research has been almost exclusively on white populations. The information relating AOD use to stress and oppression among sexual minorities again points to the need for more information about gay ethnic minorities, who arguably face even more stress than gays in the mainstream population. The USDHHS (1989:3-122) observed: Ethnic minority gay youth *"face more severe social and cultural oppression than other gay youth and far more serious problems than other adolescents."*



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## SECTION 4

### AOD USE AND HIV DISEASE

Most of the research on the association between AOD use and human immunodeficiency virus (HIV) infection has focused on the role of IV drug use in the transmission of the disease through needle sharing. In this review, however, we will be concerned more generally with the role of nonintravenous drug use as a contributing factor or cofactor. As intravenous drug users (IVDUs) are also often heavy users of alcohol and other drugs, it is possible that AOD use in general is involved in some way in the etiological connection of IVDU with AIDS (Room 1985). In this section, we will first examine the research relating to the association between HIV and AOD use in general and then specifically the issues of intravenous drug use and trends relevant to AOD use and safe sex. As most of this research concerns gay men, we will then review the limited research relevant to lesbians.

#### 4.1 ETIOLOGICAL FACTORS

Attention has focused on three possible ways that AOD use may increase risk of AIDS: (1) by leading to high-risk (HIV-transmitting) sexual activity; (2) by suppressing the immune system and thereby increasing the risk of infection; and, (3) and by potentiation of the HIV virus, thereby increasing the disease progression (e.g., Molgarrd et al. 1988; Room 1985; Stall and Wiley 1988; Stall and Ostrow 1989).

##### 4.1.1 Facilitator of High-Risk Sexual Behavior

As discussed, among gay men drug use is closely associated with sexual activity. More specifically, it appears related to high-risk sexual behavior.



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Gay men studied by Stall et al. (1986) who reported an increase from May 1984 to May 1985 in "high-risk" sexual practices reported greater AOD use during sexual activity and used a variety of different substances. The cross-sectional analysis showed that use of particular drugs during sex, the number of drugs used during such activity, and the frequency of combining drugs and sex were all positively associated with risky sexual activity for AIDS. These findings show a strong relationship between drug and alcohol use during sex and noncompliance with safe sex techniques to prevent the spread of AIDS (see also Stall 1988).

In a six-month longitudinal study of patterns of sexual behavior among asymptomatic, gay males in New York City recruited through a diversity of sources, Siegel et al. (1989) found that use of drugs other than alcohol within sexual contexts was *"clearly the most important predictor of persistent risky behavior."* In discriminant analysis controlling for a number of additional variables, it was the predictor variable that discriminated between 53 males classified as risky at both time 1 and 2 from 47 males classified as safer in both periods. Alcohol use (average drinks per month in past six months) only approached significance, but, the authors suggest, its effect may have been more pronounced had alcohol use during sexual activity been investigated, as in the drug use items. More refined analysis of polydrug use may have also more clearly indicated a role for alcohol.

Analyzing data from their sample of 2,600 gay males in Chicago, McKirnan and Peterson (1989b) found that AOD abuse was related to "high risk" sexual behavior, including the number of partners, particularly among respondents who are generally motivated to use psychoactive substances to decrease tension, self-awareness, or self-monitoring. It appears that using substances to decrease stress may not only relate to substance abuse itself, but to the role of substances in increasing HIV-risk behavior. This is seen as consistent with anecdotal reports that drugs are used to disinhibit "unsafe" sexual behavior and directly support a hypothesis that the "denial" and/or "disinhibition" expectancies that contribute to substance abuse (as reported by McKirnan and Peterson 1989, 1989a) also underlie the role of alcohol or drugs in perpetrating AIDS-risk behavior (p.169). "Bar orientation" was also



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a consistent, strong predictor of all the HIV disease measures, *"indicating that those with inadequate or inappropriate social resources are at greater risk."* The impression emerged that *"those who engage in 'risky' behavior do so as part of a larger syndrome that includes bar going, anonymous social interactions, and substance abuse"* (p. 170). Thus, two variables found by McKirnan and Peterson (1988) to underlie general AOD abuse were also important for AIDS risk: bar orientation and strong tension reduction and expectancies.

In a longitudinal and cross-sectional study of a cohort of homosexually active men at a Boston community health center, Zapka et al. (1988) also reported that impairment due to alcohol during sexual activity was associated with several less safe sexual practices.

Analysis of data from a mail survey by Leigh (1990) of the adult population of San Francisco also confirmed a strong relationship between frequency of AOD use in conjunction with sexual activity and the frequency of engaging in risky sexual behaviors. However, risky sexual behavior was not related to the proportion of sexual activity involving drinking and was related to proportion of sexual activity involving cocaine and other drugs in gay men only (not heterosexual).

Thus single-city cohort studies of homosexual men across the country have indicated both cross-sectional and sequential relationships between AOD use and high-risk sexual behavior. In addition, Ostrow et al. (1990) studied whether relationships between AOD use and high risk sexual behaviors could explain the initially observed association between AOD use and seropositivity in the Multicenter AIDS Cohort Study (MACS) of gay men in Pittsburgh, Baltimore/Washington DC, Chicago, and Los Angeles, the largest multi-site study of sexual behavior in gay/bisexual men. At baseline (in 1984), the proportion of men in the highest risk category (unprotected anal exposures with multiple partners) increased from 36 percent to 85 percent when men not using any drugs to men using three or more drugs plus volatile inhalants. As discussed below, the strongest association was with popper use. On the other hand, a lack of relationship between alcohol use and unsafe sexual practices was found once use of other drugs was controlled, probably because of the near universal use



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of alcohol in this population and lack of specific measures of alcohol use with sexual partners. However the data on alcohol was limited to total use rather than use during sex.

Stall et al. (1986) and Ostrow (1987) observed an apparent non-specificity in the relationship across drug classes, which argued against any specific psychopharmacological or aphrodisiac effect. Ostrow et al. (1990), however, found an independent effect of popper use on maintenance of high-risk behavior. Volatile nitrite use was significantly associated with failure to maintain or attain lower sexual risk levels after controlling for the effects of age, educational level, and numbers of high-risk partners. This suggest that volatile nitrite use may play an important role in the association between AOD use and high-risk sexual behavior among homosexual/bisexual men. This association is clearly related to the frequent use of poppers to facilitate receptive anal intercourse because their use helps relax the anal sphincter tone (Lange, Haertzen and Hickey 1988; Cabaj 1985b; Smith et al. 1982; Goode and Troiden 1979).

Ostrow (1986) has identified several specific hypotheses that might explain the association between AOD use during sexual activity and high risk behavior: (1) culturally learned beliefs that drugs act to disinhibit behavior; (2) certain drugs may have an aphrodisiacal effect, intensifying the libido so that control of sexual behavior is lost; (3) there may be underlying personality needs which demand concurrent use of drugs and participation in sexual behavior likely to transmit the HIV virus; (4) gays have learned to combine AOD use with high-risk sex and have found this combination of behavior difficult to change (the social context hypothesis); and, (5) the relationship is multifactorial, the result of a complex web of determinants. Although not enough research has been conducted to draw firm conclusions, it is clear that among gay men AOD use frequently occurs before or during sexual activity and that such use is associated with high-risk behaviors. Further, disinhibition and learned behavior would also appear to be especially implicated in this process. In the case of nitrites, their specific physiological effects plays an important role.



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#### 4.1.2 Infectivity

In addition, there is speculation that AOD use directly increases the risk of primary infection on first exposure by suppressing the immune system. Cabaj (1989:33) observes that *"there is clear evidence that most abused substances alter the immune system, which may well compromise the immune system's initial reaction to exposure to HIV in men engaged in unsafe sexual practices under the influence."* Much of this speculation has surrounded nitrite inhalants. However, based on his review of the literature, MacGregor (1988:48) concluded: *"This thesis is completely speculative, and is raised solely to underscore the distressing lack of any information regarding the effect of alcohol or other drugs on the resistance of animals to primary viral infection."*

#### 4.1.3 Disease Progression

As MacGregor (1988:30) observes: *"One of the biggest mysteries of the epidemic to date is the identification of the factors which cause individuals to move from the large infected-but-asymptomatic pool into the group with symptoms."* Considerable attention has focused on the role of continued AOD use.

In the Multicenter AIDS Cohort Study (MACS) of gay men in Pittsburgh, Baltimore/Washington DC, Chicago, and Los Angeles, Kaslow et al. (1989) could not detect any adverse effects from AOD use on either immunological or clinical sequelae of HIV infection. In this large cohort, which included 1,597 alcohol drinkers, 109 nondrinkers, 1,662 users of ten classes of other drugs and 83 nonusers, AOD use did not enhance the progression of infection. The proportion of seropositives at enrollment who developed AIDS during the following 18 months ranged from 5.5 percent to 8.2 percent in 1,597 alcoholic drinkers compared with 9.2 percent in 109 nondrinkers with no clear trend according to use. For other drugs, the rates ranged from 6.3 percent to 9.6 percent for 1,662 users vs. 7.2 percent for 83 nonusers prior to enrollment. Among seropositive men with low initial T helper lymphocyte counts, those who continued to use drugs showed no significantly higher



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18-month risk of AIDS than nonusers (13% vs. 10%); the corresponding risk rates were 13 percent and 15 percent, respectively, for continued heavier vs. continued lighter consumption of alcohol. No other manifestations of immunodeficiency were positively associated with substance use prior to enrollment. Prior use was not associated with low mean T helper cell counts at enrollment, and continued drug or alcohol use after enrollment was not associated with greater subsequent decline in counts. These findings supported other unpublished local reports from New York and San Francisco. However, the authors note that the number of parenteral drug and opiate users was small and Des Jarlais et al. (1987) reported that IVDUs in New York who ceased or diminished their drug use were less likely to show evidence of HIV progression than those who continued use.

SanGiovanni (1990) examined the association of a history of drug use for the six months and seven years preceding hospitalization with neuropsychological (NP) status in 46 gay men with AIDS. Drug use, predominantly alcohol and marijuana, was found in 93 percent of the sample, but it was primarily mild to moderate. There was a significant decrease in use from the seven year to the six month levels of use. Drug use was not found to be significantly correlated with NP performance, contrary to expectations.

Again, nitrite inhalant use has been especially implicated in disease progression. Nitrite inhalants have been associated with Kaposi's sarcoma (KS) in HIV disease, although *"the mechanism of action of nitrites as a cofactor in KS, if any, has yet to be elucidated"* (Haverkos and Dougherty 1988:vii). There are important reasons for considering nitrite inhalation as a factor in the development of HIV-related KS in young male gays. These are: (1) toxic pharmacologic properties; (2) mutagenic, teratogenic, and carcinogenic products resulting from metabolism of N-nitroso compounds; and (3) deleterious effects of volatile nitrites on human lymphocytes both in vitro and in vivo. They have been related to the epidemic by: (1) the timing of their popularity as recreational drugs and the subsequent outbreak of the AIDS epidemic (7 to 10 years); (2) their extensive use among gay males; (3) virtual universal history of use by young gay males in whom KS has developed; and, (4) the



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age group in which KS is developing is consistent with a cohort initially exposed 7 to 10 years ago (Haverkos and Dougherty 1988 11-12).

However, the evidence is inconclusive. The association between nitrite abuse and development of KS has been demonstrated in some studies (Marmor et al. 1982; Haverkos et al. 1985), but not others Polk et al. (1987). In a review of six epidemiologic studies on this association, Haverkos (1988:101) found a strong association in three studies but not in three others. Nevertheless, he concludes that drug is the most likely cofactor based on current knowledge.

## **4.2 INTRAVENOUS DRUG USE**

As with intravenous drug use in general, specific information about the relationship between IVDU and sexual behavior as HIV risk factors among gay males are rare. In large part this appears to be due to the low prevalence of the IVDU in this population. It has also been found that IVDU does not significantly add to the HIV risk among this population posed by high-risk sexual behavior (John Newmeyer, personal communication). Supporting this, in a provocative study, Stall and Ostrow (1989), as part of the San Francisco Men's Health Study, examined the differences in sexual activity among gay male intravenous and nonintravenous drug users. They not only found a strong association between drug use and risky sexual behavior but also that HIV infection is more likely to occur as a result of engaging in risky sexual behaviors while intoxicated than as a result of sharing needles. Although the gay IV drug user represented a relatively small minority (8 percent of the total sample), nearly all of the men who used needle drugs also combined some form of drug use with sexual expression. (Men in the older age cohorts appeared to be more likely to have sex without alcohol or other drugs.) Prevalence rates of HIV seropositivity were highest among gay needle users who also combined drugs with sex.

Data did indicate that there may be an additive risk for HIV infection both from combining drugs with sexual activity and from using drugs intravenously. However, men who



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used needles and combined drugs with sex participated in higher risk sexual activities and thus may have a higher prevalence of HIV antibody unrelated to needle use patterns. Men who combined drugs with sex had a seroconversion rate nearly 3.7 times greater than men who neither combined drugs with sex nor used needles (p. 66). Gay men who neither combined drugs with sex nor used needles had the lowest prevalence rates of engaging in high-risk sexual behavior. Over 70 percent of all acts committed by antibody-positive men which hold a high potential for infecting a partner were by men who did not use needles, but did combine drugs with sex. This is in part because of the low prevalence of needle-using among gay men in this population.

In the study of 336 male IVDUs recruited in street settings in San Francisco in 1989 by Lewis and Watters (1990), the majority of the 43 (13 percent of the total sample) who reported having both male and female sexual contact, engaged in high risk sexual behavior. Bisexually active men more than heterosexually active men reported exchanging sex for money or drugs. Many (49%) of the men having sexual activity with both men and women self-identified as heterosexual.

### 4.3 TRENDS

Several studies indicate that gay males have reduced in conjunction their AOD use and their high-risk sexual activities, adding support to the evidence that the decline in use that has occurred has been in large part due to concerns over HIV infection. Stall and Ostrow (1989) report that gay needle users had an impressively high rate of decline (34%) in high-risk sexual activities from the first to the second wave of data collection in their San Francisco Men's Health Study. This data suggests that gay male needle users are capable of making important reductions in high-risk sexual activity over a short period of time. Furthermore, it appeared *"that the group from which HIV infection is most likely to spread are those men who combine drug use with sexual activity, but who do not use needles"* (Stall and Ostrow 1989:71).



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In an examination of change in both recreational AOD use and risky sexual practices, McCusker et al. (1990) found that use of marijuana, nitrite inhalants, and cocaine, the most popular illicit drugs among the cohort, decreased by 25 percent to 48 percent during 42 months of followup. Those who continued to use each drug reduced their use frequency. Men who initially reported both high-risk sexual practices and AOD use and who subsequently stopped or reduced their use were significantly more likely to stop those unsafe sexual practices than were those who continued to use these substances. These findings are limited by the study's potential selection biases and the failure to take into account HIV antibody status of sexual partners or to examine whether such use was associated with sexual activity. Nevertheless, the study indicates that the group of men who report impaired judgment due primarily to recreational drugs are having particular difficulty with sexual control.

#### **4.4 LESBIANS**

Little is known about HIV risk behaviors or HIV seroprevalence among lesbians, much less the association between AOD use and HIV risk. However, at least one study indicates a low risk from IVDU among lesbians. Among a sample of 28 IVDU women in San Francisco who had had sex with another woman within the past five years and had used intravenous drugs within the previous three weeks, almost all had shared needles in the last five years but used bleach to clean them, the majority 75 percent of the time or more (Case et al. nd). Almost all had female sex partners who were also IVDUs.

#### **4.5 CONCLUSIONS**

Taken together, these studies suggest a rather strong relationship between AOD use and high-risk sexual activity, at least among high-socioeconomic status gay and bisexual men during the mid-1980s, when HIV transmission was at its peak among this population. AOD use clearly should be viewed as a barrier to adoption of safer sexual practices for the



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prevention of HIV transmission. Again, nitrite inhalants emerge as especially implicated in risky behavior. However, at this point the evidence indicates that the primary cause of this relationship is the close correspondence of drug use and high risk sexual practices due to disinhibiting effects, the association that develops among many gay men between AOD abuse and high-risk sexuality, and even use of drugs to facilitate these practices, as in the case of nitrite inhalants.

In light of Siegel et al.'s (1989) and Ostrow et al.'s (1990) finding that this risk factor applied to illicit drug use more than alcohol use, possible drug differences need to be examined, although other studies implicated the use of alcohol as much as other drugs. Given the sexual disinhibiting effects historically associated with alcohol, this finding warrants further research, especially in light of McCusker et al.'s (1990) finding that their sample reduced use of other drugs but not alcohol. More research needs to be undertaken to determine what proportion of the gay population abuse alcohol and other drugs in general, what proportion combine drug use with risky sexual behavior, and what proportion also use needles.



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## SECTION 5

### PREVENTION AND TREATMENT

If the prevalence of AOD abuse among sexual minorities is not as extensive as once believed, it is nevertheless extensive and troubling. Unfortunately, not much attention has been directed toward how to address the prevention and treatment needs of this community. Although numerous discussions exist, most concern themselves with just alcohol or AIDS-related issues. Both program development and research has been limited. Therefore, in this section we will summarize the current state of information about prevention and treatment efforts and what has been recommended by practitioners to improve the situation.

First issues involving AOD use in general will be explored, then the specific problem of the connection between AOD use and HIV disease. Because of the nature of the literature, much of the information concerns alcohol, but much of this is also applicable to other drug use.

#### 5.1 PREVENTION

There is a growing recognition that for prevention campaigns to be effective they need to be designed to address the characteristics and needs of specific populations at risk. Although gays and lesbians are clearly such a "high-risk" population, and have been so identified by the US Office of Substance Abuse Prevention, there are few guidelines in the literature about how to most effectively conduct a prevention campaign targeting them.

Mongeon and Ziebold (1980) present an alcohol abuse prevention model for the gay and lesbian community. The approach is grounded in the belief that such a program must be sensitive to the values and norms of the target population, be conducted by trusted and visible community members, involve a broad spectrum of the community leaders and opinion



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makers in its planning and implementation, and be integrated into the existing institutions and service delivery networks within that community.

The following are some of the specific aspects of prevention efforts targeting the gay and lesbian communities that do emerge from the literature:

- Community Education Campaigns. Specific intervention efforts should be accompanied by a public education and/or outreach campaign utilizing the formal and informal communications networks of the sexual minority community and involving broad community representation in order to heighten awareness of the adverse consequences of AOD misuse and to develop additional alternative outlets for social activities (Mongeon and Ziebold 1980).
- The Bar Scene and Alternative Activities. Although the role of bars in the etiology of alcoholism may have been exaggerated, a prevention campaign should take into consideration the unusual role of gay bars as community centers (Israelstam and Lambert 1984; Room 1985; Stall and Wiley 1988:71). In general, Kus' (1988) finding that gay bars were not the primary influence on the etiology of alcoholism implies that *"striving for alcohol-free alternatives to gay bars will unlikely lower the incidence of alcoholism in the gay community."* This needs to be explored further in the research. There is little doubt, however, that alternative places for sexual minorities to meet and socialize other than the bar and nondestructive social outlets in general, need to be encouraged (Saunders 1984). Even Kus (1988:37) maintains that this may be especially important in enhancing the possibility of recovering gay alcoholics to maintain sobriety.

Mongeon and Ziebold (1980) recommend an intensive, experimental group process that will encourage participants to develop more constructive alternative behaviors to drinking and bar attending in their lives.

- The Dangers of Multidrug Use. The finding of high rates of multiple drug use indicates that education campaigns should publicize the specific dangers to health of multi/concurrent drug use.



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- Targeting Older Age Groups. McKirnan and Peterson's (1989) finding of far less of a decline in reported alcohol and other drug use as the gay and lesbian populations aged indicates more attention needs to be directed toward the older ages, whereas general population prevention and intervention is targeted at younger population.
  - Early Intervention. For many coming out, AOD use may be a prerequisite to approaching others of the same sex and engaging in sexual behavior. Counselors working with adolescents and people first dealing with their sexual orientation should address the role of AOD use within the gay and lesbian community in general, and specifically AOD use as it relates to HIV-risk. This is especially true of adolescents and young adults, those in the age range of highest drug use in our society. Unfortunately, very little is known about AOD use among gay, lesbian, and bisexual adolescents to serve as a guideline for prevention.
  - Acceptance of Gayness. Because alcoholism is primarily linked, in Kus' (1988) findings, to nonacceptance of gayness, the community should continue striving to reduce homophobia and increase gays' self-esteem.
  - The Dangers of HIV Infection. One of the most effective motivations for gay males to make changes in their AOD use is fear of HIV disease. As discussed further below, the potent message that AOD use in the context of sexual activity appears to increase the risk of HIV infection by promoting risky sex and that some drugs (i.e., amyl and butyl nitrites) may contribute to disease progression needs to be stressed and incorporated in all HIV education campaigns and materials (Siegel et al. 1989; Stall et al. 1986:265; Stall and Wiley 1988:71).

## 5.2 TREATMENT

There is a considerable body of literature, most relatively recent, that has been written by practitioners based on their own experiences of the special clinical and treatment needs of gays, lesbians, and bisexuals. Again, there is very little research to substantiate these observations and most of this literature deals with alcohol. But the evidence is clear that the needs of this community have not been met by treatment providers.



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As an authority figure whose approval or disapproval typically carries a great deal of weight, it is important that the therapist communicate sensitivity and understanding to gay and lesbians clients. Even more important, as Schaefer, Evans, and Coleman (1987) stress, in treatment it is absolutely essential that clients be able to not only deal with the harmful consequences of AOD use, but also with the feelings that they have about their identity, sexuality, and lifestyle -- all elements that are intimately related to their AOD use.

Clinical interventions must be aimed at helping clients achieve a more functional resolution of sexual orientation concerns. There is universal consensus that, although there are many similarities in the treatment approaches required in dealing with AOD abusers in the gay and lesbian community and in the heterosexual community, the significant differences between the two must be taken into consideration as well. As coping skills deficits may be a major cause of AOD-involvement and relapse, counselors need to address social issues specific to being AOD dependent and a sexual minority. Furthermore, an important part of early recovery is the process of self-analysis and redefining oneself. Because alcohol or other drugs may have served as a crutch to deal with the intrapsychic conflicts created by same-sex desire and societal disapproval, clients in recovery may find themselves going through a process of redefining themselves sexually and coming to terms with their homosexuality or bisexuality (Colcher 1982; Sterne, Schaefer, and Evans 1983). Unfortunately, few treatment programs have either sought out or specifically addressed the needs of sexual minorities with substance-abuse problems.

### **5.2.1 Service Provision and Utilization**

The extent to which mainstream facilities currently address the needs of AOD abusers in the gay and lesbian community is unknown (Hellman et al. 1989:1164). However, several studies, predominantly from California, have examined treatment utilization and experiences within this community. Although gays and lesbians have been long identified as a population at higher risk of AOD abuse than the general population, these studies clearly



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indicate that few programs have made any effort to attract gay and lesbian AOD abusers or to take into consideration their differences from the general population in the treatment process. Studies consistently have found a lack of formal training, limited knowledge of community resources, inability to identify gay clientele, little or no gay staffing, failure to actively address the unique treatment issues of this population, judgmental attitudes about sexual minorities, and little or no priority for creating more supportive treatment environments for them. Program staff have been largely untrained and insensitive to gays and lesbians. Sexual issues generally have been unaddressed or sexual orientation becomes the focus of the intervention (Coleman 1987). Even when program staff recognized that gays and lesbians have special service needs, programs rarely address these needs.

For example, Lohrenz et al. (1978) found that 37 percent of gays and lesbians experienced discrimination from professional treatment agencies. Fifield (1975) reported that out of a total of 54,000 clients treated over a six-month period, known gay people numbered only 500-600 or about 1 percent. Only four of 46 agencies made any attempts to do outreach to gay alcoholics. Only two agencies had meetings or therapy groups designated for gay people. As noted by Paul, Bloomfield, and Stall (Forthcoming), *"these numbers were primarily based on staff assumptions about their clients' personal appearance and mannerisms, as few were open about their sexual orientation."* Fifield (1975) found that fewer than 25 percent of the alcohol-treatment agencies in her study provided staff training in working with homosexuals and acknowledged gays constituted only 2 percent of the staff. Similar findings have been reported by Smith and Schneider (1978) and Zigrang (1982).

Finnegan and McNally (1987) reported on lack of knowledge about the interrelation of alcoholism and homosexuality. Critical factors associated with sexual orientation that contribute to drinking problems were not examined (Zehner and Lewis 1983). On the other hand, frequently treatment inappropriately focused primarily on sexual identity when help was sought for alcoholism (Finnegan and McNally 1987; Driscoll 1982).

In San Francisco, a 1977 study (Judd 1978) found that only 12 percent of mainstream



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agencies referred openly gay clients to gay-identified agencies. In addition, 33 percent could not identify their gay clientele, and only 21 percent of agencies had openly gay staff. A 1983 survey by Morales and Graves (1983), only 38 percent of treatment providers reported some formal education in treatment of homosexual alcoholics. Less than half of respondents could list a referral source for gay or lesbian clients (44%) or 42 percent knew where to get information and only 23 percent knew of specialists in private practice who worked with this population. Two-thirds (66%) of treatment providers contacted would not participate in the study because of objections to questions that rated the therapists degree of homophobia, *"suggesting that treatment providers resist exploring personal attitudes that may hinder the ability to work with homosexual patients"* (Hellman et al. 1989:1166). Although 60 percent of gays and lesbians would prefer a counselor of the same sexual orientation, most treatment providers (65%) reported no gay staff or did not know if there were openly gay staff at their facility.

Hellman et al. (1989) conducted a survey of alcoholism treatment providers in 36 government-funded mainstream agencies in New York City. The 164 respondents had limited knowledge about how to evaluate and treat homosexual alcoholics and frequently did not discuss sexual orientation with their clients even though they considered it important. The training and supervision of most providers in the treatment of alcoholic sexual minority clients was substandard or nonexistent. Respondents reported that development of programs for sexual minority alcoholics had little priority in their facilities. Many also believed that homosexual alcoholics are less likely to seek help and may have more difficulty achieving sobriety. However, 86 percent expressed desire for more training in this area, suggesting a broad consensus that significantly greater efforts are necessary. This may signify a trend toward greater consideration of health care needs of gay and lesbian individuals. There was still a lack of quality education on alcoholism among them, as well as an almost total absence of informed supervisory experience.



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These findings suggest little progress has been made in program development since the studies by Fifield and Judd. They indicate that only four percent to nine percent of mainstream agencies provided outreach to gay alcoholics, only two percent to four percent had groups or meetings for gays, and only one percent to seven percent had same-sex couples in counseling (Hellman et al. 1989:1167). However, contrary to earlier reports, respondents reported no discomfort in working with homosexuals.

Confirming these studies, many clients entering the gay-specific Pride Institute reported that they had never talked about issues relating to their sexual orientation in prior inpatient alcohol treatment settings (Ratner 1988). Underhill (1982) observed that the majority of lesbians who came for services from the Alcoholism Center for Women reported having unsuccessful treatment attempts at nongay agencies. Many reported that at these agencies the issue of their lesbianism as a negative life style was seen as central to their alcoholism. Underhill stresses that not only are traditional programs unresponsive to the needs of lesbian alcoholics but they also often make the erroneous assumption that lesbianism is a causative factor in alcoholism. Regarding issues specific to lesbians, Mills and Nelson (1982) emphasize that counseling AOD-dependent lesbians is difficult because many counselors do not know enough about them and try to treat the lesbianism, or else believe that lesbians are so similar to heterosexual women that the differences are ignored.

Not surprisingly, dissatisfaction with the treatment process has been frequently found. Fifield (1975) reported that three-quarters of gay and lesbian recovering alcoholics believed an accepting and supportive environment is not available in agencies that are not oriented to treating gay clients, and that there was a heterosexual bias in therapists' evaluation and treatment. Gays and lesbians have reported discomfort in predominantly heterosexual treatment settings (Tapper and Sauber 1986) and fear of being viewed pathologically or stereotypically (Rabin, Keefe, and Burton 1986). Many gay men indicate a history of nonacceptance, prejudice, and a lack of understanding in their encounters with counselors and psychotherapists (Bell and Weinberg 1978; Saghir and Robins 1973).



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The low attendance in treatment or unwillingness to identify themselves as gay or lesbian has further minimalized the perceived need within treatment services to address the needs of this population, thus perpetuating the continuance of the problem. Equally as important, the treatment process itself has been impeded. *"Given the number of gay/lesbian clients in mainstream treatment programs who do not disclose their sexual orientation, it appears that many do not deal with the important issue of developing self-acceptance"* (Paul, Bloomfield, and Stall. Forthcoming).

There are, of course, exceptions. A 1987 "sexual minority window survey" of 17 San Francisco alcohol programs found counselors reporting 23 percent of their clients to be lesbian, gay, or bisexual. This higher utilization rate may lie in the size of the city's gay community, but it appears as well to be due to the public health policies of the city, which have targeted sexual minorities as a special risk population (Madovar 1988; Vasquez, Frazer, and Stevenson 1989). In the next section, we shall explore some of the specifics that can be done to improve service delivery.

### **5.2.2 What Should be Done?**

There are numerous articles that make recommendations for developing more sensitive and effective treatment programs. All writers emphasize the need for a supportive and nonjudgmental environment. For example, Nardi (1982) stresses that in treating gay men and lesbians for alcoholism, it is important to recognize that alcohol use has been seen as a necessary component of the lifestyle and that the nature and types of gay relationships, often formed in reaction to heterosexual society without social and legal recognition, create unique dynamics and structural issues. Relationships and roles enacted in the family of origin system, extended family systems of close gay friends, and the same sex couple systems provide contexts significantly different from traditional heterosexual family systems. Understanding how gays and lesbians define their lifestyles, create meanings for alcohol use in their subculture, and negotiate the unique demands of alternative family structures are



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essential for achieving comprehensive and successful prevention and treatment programs serving them.

Unfortunately, there is little systematic research on the relative effectiveness of different treatment modalities and approaches for working with sexual minorities (Anderson and Henderson 1985). Most reports are anecdotal and involve small samples. Among the issues that emerge is the extent to which gay-specific programs are preferable to mainstream programs.

### **5.2.3 Gay-Specific or Oriented Programs**

Most programs that address these issues have been alternative treatment centers originating within the gay and lesbian community (Tapper and Sauber 1986; Vachon 1987). Ratner (1988) describes a holistic model for treating lesbian and gay people developed at the Pride Institute. If mainstream treatment has failed to address the needs of the gay and lesbian population, a major issue raised by many commentators on the problem is whether they can even be treated adequately by them (e.g., Vourakis 1982:40). Rather, it is argued, segregated programs specifically for sexual minorities need to be created. It appears that gays and lesbians, as well as bisexuals, are more willing to attend gay-sensitive programs (Colcher 1982; Driscoll 1982; Jones et al. 1980). However, there is no evaluation research that conclusively demonstrates that gay-specific treatment agencies are more effective than mainstream programs. Evidence about the effectiveness of gay-specific programs is inconclusive.

Success rates have been reported to be higher in such programs. Three gay-identified programs studied by Fifield, Latham, and Philips (1977) reported markedly higher treatment success rates for their sexual minority clients than did mainstream programs. Preliminary reports from the Pride Institute (Wert and Roiblatt 1990) suggest unusually high treatment success rates (as measured in terms of maintaining sobriety). However, the findings of these studies are limited by small sample sizes and lack of followup and standard operational outcome definitions (Paul, Bloomfield, and Stall. Forthcoming).



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Paul, Bloomfield, and Stall (Forthcoming) observe that *"perhaps the best argument for the need for programs tailored specifically for gay men, lesbians and bisexuals has been the explosive growth of gay Alcoholics Anonymous groups."* In 1968, only two existed; by 1974, 16; today, 500, with gays and lesbians the largest special interest group within AA. In San Francisco, 115 out of 560 weekly AA groups are oriented toward them and annual conferences with over 4,000 participants have been held. *"In addition, AA has been said to appeal to lesbians and gay men due to its 'decentralized democratic' organizational structure, which feels familiar to people experienced in grassroots political movements. It is precisely because of this structure that lesbians and gay men have been free to establish AA meetings of their own (Herman 1988)."*

A preliminary report of the Orange County (California) Gay Alcoholic Needs Assessment Project (Jones, Latham, and Jenner 1980) examined differences in perceived social environment within recovery facilities as experienced by gay and nongay recovered alcoholics. Results of profile scores indicated that both groups want much of the same thing from a treatment environment: a program that places strong emphasis on the relationship dimension and a personal problem orientation. Gay subjects reportedly wanted more emphasis on staff control. In reference to the controversy of whether gays should be treated in their own separate facilities, only about half chose to go to "all-gay" facilities. Nevertheless, they also wanted not to hide the gay part of their identify.

Fifield (1975) argues that effective intervention can only be achieved in a separate treatment facility for lesbians. Fifield (1975) recommends that programs must provide a safe supportive environment for interaction with peers; an understanding of societal oppression and discrimination as it affects homosexuals; and freedom to focus on the issue of sexual orientation and how it relates to alcoholism. These goals, she argues, can only be achieved in a separate treatment facility for homosexuals. Integrated treatment programs also raise the difficulty of the client deciding whether or not to come out as part of the treatment process (Nicoloff and Stiglitz 1987).



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### ***Self-Help Groups***

There is a general consensus that more gay-specific self-help groups are needed, such as gay AA or Al-Anon groups (Saunders 1984). These are important not only as they facilitate treatment, but as they provide a much needed system of support for recovery and a social network for maintaining a new drug-free lifestyle away from the temptations of bars. Bloomfield (1990) *"compared the social network structure of gay and lesbian AA members across various lengths of AA membership."* She found a significant increase in the number of other gay recovering alcoholics within the social networks. Among those with less than one year in AA, about half of their social network consisted of other lesbian or gay recovering alcoholics; this proportion rose to three-quarters among those in AA for at least six years. Bloomfield also found that these members of the social network provided a high level of social support. Thus, membership in AA for gay alcoholics was associated with the apparent retention of other gay friends supportive of their recovery.

### ***The Limits of Gay-Specific Programs***

However, there are a number of limitations to the gay-specific programs. First, gay-oriented programs may be feasible only in larger metropolitan areas, and few can offer comprehensive services. Second, they may be inappropriate for individuals who are unsure of their sexual identity, *"at a stage of social reintegration requiring a more heterogeneous environment,"* or desirous to hide their sexual orientation from others, such as employers (Hellman et al. 1989:1163-1164). Similarly, the problem with gay AA groups is that many gays in recovery may not have come-out or do not feel comfortable in such meetings. Kus (1988:35) also observes that, while gay AA meetings and gay groups of all types outside the bar may be helpful, *"because the gay doesn't achieve true self-acceptance of being gay until after sobriety is chosen--and lived for awhile---initial contact with gay AA groups may be uncomfortable."* Finally, there is some evidence that clients themselves do not prefer segregated programs. The majority of respondents surveyed by Morales and Graves (1983)



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preferred having specialists in homosexual alcoholism within mainstream agencies, followed by mainstream agency, followed by specialized program.

### **5.3 MAINSTREAM PROGRAM STAFF DEVELOPMENT**

More efforts therefore need to be undertaken to determine whether mainstream programs can be made more sensitive and responsive to gay and lesbian clients. To do so requires both increasing gay staff and training existing staff. Several reports document feasibility of modifying existing traditional alcohol treatment programs through enhanced education, training, supervision, and organizational changes (Smith and Schneider 1981; Rabin, Keefe, and Burton 1986; Hellman et al. 1989:1164). Zigrang (1982) provides a model inservice staff training program. Generally, it is recommended that counselors be educated about how to:

- develop rapport with clients
- be sensitive to the dynamics of same-sex relationships and how it relates to AOD abuse
- be aware of local community resources, including:
  - gay AA groups
  - local gay groups
  - alternatives to gay bars (Schaefer, Evans, and Coleman 1987; Paul et al. Forthcoming)

#### **5.3.1 Heterosexual Staff Bias**

As part of the process of promoting staff sensitivity, AOD professionals need to become more aware of the role that one's attitudes and assumptions about sexual orientation can play in providing services to clients. The issues of any internalized homophobia and feelings of resistance or anxiety among practitioners in working with sexual minorities needs to be addressed, especially as it is complicated by fears of HIV infection. If prejudices



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might interfere with providing assistance, staff either need to work to change these attitudes or not work with gay/lesbian clients (Paul, Bloomfield, and Stall. Forthcoming)

In this regard, DeCrescenzo and McGill (1978) found that homophobia was least evident among psychologists, moderately evident among psychiatrists, and most prevalent among social workers. In regard to lesbians, it has also been observed that homophobic practitioners tend to underestimate the daily stress of their lives, encourage superhuman expectations, and ignore issues specific to lesbian relationships (Anderson and Henderson 1985:522). Cabaj (1989:389) calls homophobia the greatest barrier to obtaining quality health care and AOD treatment. Homophobia is the major factor in the special treatment barriers to gays and chemical dependence treatment as well as to proper care and prevention of HIV-related infections. Alcoholic gays face the dual oppressions of internalized homophobia and alcoholism both active and in early recovery: denial, fear, self-loathing, guilt, self-pity, depression, dishonesty, isolation, and fragmentation (Finnegan and McNally 1978).

### **5.3.2 Promotion of Gay Staff**

It is equally important to increase the number of openly gay and lesbian staff, especially for any program in areas that serve this community. About half of the providers surveyed by Hellman et al. (1989) believed that treatment programs would benefit from having openly gay staff and felt that being openly gay carried little professional risk. Among the advantages of having gay staff that have been identified are:

- The client who identifies as a minority group member usually anticipates greater acceptance and understanding from a counselor who belongs to a similar minority.
- They can provide a positive role model for client identification.
- They can serve as an important resource for heterosexual staff working with gay clients.



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- They can help change misinformation and negative biases that may exist among other staff members.

For similar reasons, treatment programs frequently employ recovering substance abusers as counselors.

## 5.4 STRATEGIES AND APPROACHES

Regardless of whether a program is limited to gay and lesbian clients or not, there are a number of issues that emerge in the literature that need to be taken into consideration in meeting client needs. Among the following are some of the specific factors that need to be taken into consideration in providing intervention services.

- Co-Dependents and Significant Others (Collateral Counseling). Treatment specialists have increasingly recognized the importance of involving the family in the recovery process. Because gays and lesbians are usually viewed as single persons, the effects of their AOD use on their loved ones is often overlooked (Israelstam and Lambert 1989:61), as well as the involvement of their lovers in their drug-dependent behavior as codependents. There are also several impediments to involving the nuclear family in the recovery process: sexual minorities are also often estranged from their nuclear family, or they may have hidden both their substance abuse and their sexual orientation from them. Thus, consideration must be given to inclusion of involvement of significant others and the gay/lesbian's extended family (Nicoloff and Stiglitz 1987). Nardi (1982: 88, 1982a) discusses alcoholism treatment objectives involving the nontraditional "family," arguing that treatment must involve client lovers and that successful intervention *"depends on restructuring the norms and roles of the extended family system."*

Lovers and friends must especially be involved if they play the role of codependents unwittingly enabling drug-dependent behavior to continue. Counselors must seek to determine whether someone in the clients' life may be contributing to client difficulties by helping avoid confronting the problem, often because of the sense of being needed by the dependent person that they derive from the relationship (Mills and Nelson 1982:453). Whitney (1982) describes treatment strategies for gay male coalcoholic.



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- Counseling AOD Problems and Sexual Orientation. Although any counseling for AOD problems must address the role of sexual orientation and the lifestyle of sexual minorities in America, there are a number of issues yet to be resolved in the ways and means to go about doing so. Most practitioners recommend that, first and foremost, the alcohol and/or other drug consumption needs to be stopped, that while the issue of sexual orientation needs to be addressed, it should not be treated as the primary problem. Kus' (1988) finding that only after choosing and living sobriety did gay alcoholic men accept being gay as a positive aspect of self suggests that AOD-dependent sexual minorities in therapy should be treated first for the AOD problems before proceeding to issues involving their sexual orientation, or at least concurrently. In his words, alcoholism clinicians "*first and foremost [should] assist the client achieve the Acceptance stage of the coming out process*" (p. 37). Glaus (1989:134) similarly stresses that "*the first goal of treatment with the alcoholic or chemically dependent lesbian must be to terminate the alcohol or drug use,*" whereas many therapists approach AOD problems "*by attempting to deal with the underlying issue*" presumed to cause it. This, he believes, colludes with the denial system of the alcoholic and is a waste of time and money. Based on clinical experience counseling 75 gay and lesbian alcoholics, Colcher (1982) emphasizes that in dealing with both those who are comfortable with their sexual orientation and those who feel it is as much a problem as their alcoholism, sobriety must come first. Awareness and sensitivity to sexual orientation is essential but it should not be treated any differently than any demographic factor (p. 46).

McNally (1990) observed a similar progression in therapy. She examined the dynamic interaction between sexual identity and drinking, alcoholism recovery, and ongoing sobriety among eight white, middle class lesbian recovering alcoholics in Alcoholics Anonymous. Five themes emerged in stages of their lives: (1) sense of being different, alone, and afraid; (2) drinking to cope with being a lesbian; (3) recovery and sobriety as a life saver; (4) acceptance of lesbian identity in sobriety; and, (5) acceptance of being a lesbian recovering alcoholic.

Saunders (1984) concluded that, to attain sobriety and to eliminate the self-destructive behavior associated with alcoholism, agencies and treatment centers must not only accept gays and lesbians for treatment, but treat them without discrimination and without trying to "cure" their homosexuality.



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- AOD Use and Sexual Behavior. AOD treatment professionals need to specifically explore the connection between AOD use and sexual activity. As Smith (1982) observes, some gay clients may have never experienced "sober sex," and may be unused to the communication around sex necessary for a satisfactory experience. Sex and substance use may be so strongly related in their minds that sex becomes a "slippery" situation that creates high-risk for relapse. The knowledge and facility to work with clients on relationship and sexual issues may be as important to relapse prevention as dealing with situations where one is offered a drink, he concludes, and requires non-judgmental, "sex-positive" attitudes on the part of people involved. This is especially important in light of the connection with AOD use and sexual behaviors that place clients at high risk of HIV infection.
  - Should Counselors Promote the Coming Out Process? Counselors also need to address the particular problems faced in coming out to family and nonlesbian friends (Underhill 1982). Mills and Nelson (1983:465) warn that counselors must not fall into the trap of unwittingly promoting the coming out process on the assumption it is necessary. Many clients may not have any alternative support if they reveal their sexual orientation. This is especially important in working with ethnic minorities, who may have greater fear of openly admitting their sexual orientation to family and friends.
  - Group Counseling. Most drug treatment agencies rely on printed materials to educate clients, but high school dropout rate is very high among drug abusers. *"Again, face-to-face counseling in a private or group setting seems to be the most effective educational device"* (Murphy 1987:391).

Group therapy is the treatment modality almost universally recommended (Smith 1982; Underhill 1982; Weathers 1980). An important part of recovery is getting support for changing one's pattern of abuse. Group work provides this support, helping recovering AOD abusers overcome feelings of self-contempt, isolation, loneliness, and alienation. Its advantages include:



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- making contact with others for support and an end to isolation;
  - learning that problems are not unique and providing an opportunity to understand these problems and share ways of dealing with them; and
  - contributing to a sense of self-worth by encouraging and supporting others in a helping role.

It may be especially valuable in working with gay and lesbian adolescents, for it provides opportunities to:

- validate clients through hearing peer thoughts and experiences;
- develop socializing techniques; and
- provide successful adult models (DeCresenzo 1979; Mills and Nelson 1983:463-466).

Group leaders must therefore work to establish rapport with members, create a climate conducive to self-disclosure, avoiding morality or judgments, affirming worth of group members. Even within mainstream treatment, group therapy probably should be limited to same sex groups, as it is harder to do in mixed groups.

- Internalized homophobia/biphobia. The clinical reports of Kus (1988) and Marschall (1980) stress the importance of dealing with internalized homophobia to maintain sobriety.
- Relapse Prevention. Developing social networks and support systems is a crucial part of relapse prevention. Working with families is an important component of this process with heterosexual patients; but, as many gays, lesbians, and bisexuals experience rejection from their nuclear families, alternative sources of social support are important, such as friendship networks. To do this requires understanding of dynamics of same-sex relationships. Gay self-help groups such as AA may be especially important in this regard. Paul, Bloomfield, and Stall (Forthcoming) observe: *"As the desire for alcohol may be cued by both environmental and psychological triggers specific to being gay, any relapse prevention/coping skills training programs would need to include such situations in the time spent on planning and behavioral*



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*rehearsal."* Colcer (1982:47), however, notes that patients in recovery often go to bars with other nondrinkers to provide support and, although this needs to be closely monitored, it is not necessarily an obstacle to recovery.

## 5.5 LESBIANS

While much of what has been said applies to all sexual minorities, there are similarities and differences in regard to prevention and treatment among them that need to be taken into consideration, differences that in large part are rooted in the differences in lifestyles, situations, and AOD use correlates.

Smaller proportions of lesbians have been found to present themselves at treatment agencies than heterosexual women (Weathers 1980). Lesbians face many barriers that result simply from their status as women. As summarized by Paul, Bloomfield, and Stall (Forthcoming), women's wages continue to be lower than those of most men, imposing a gender-linked economic barrier to quality health care; models of psychotherapy have traditionally been male-oriented, and models of health have been biased in favor of men. Lesbians face not only negative reactions and stereotyping in regard to their sexual orientation but also to the female AOD abuser.

Nicholoff and Stiglitz (1987) stress the following important program components:

*For lesbians, who may approach agencies with more misgivings than other potential clients, perceptions of a particular agency as helpful will be influenced by staff composition (number of women, lesbians, and recovering lesbian alcoholics), types of services available (women's groups, lesbians groups, and child care) and by the philosophy of the agency conveyed in outreach activities. In the absence of a conscious effort to do otherwise, an agency may easily inadvertently limit lesbian participation in its services.*

Group therapy is especially recommended for lesbians because individual counseling continues to reinforce their problem of isolation. Lesbians need to feel the support of other lesbians that group therapy can provide. For similar reasons, the therapy may be best



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facilitated by lesbian staff (Underhill 1982). The gender of treatment practitioners emerges as an important issue within the lesbian community. As noted, practitioners generally recommend that the sexes not be mixed in group therapy. Lesbians may need an opportunity to address certain problems without the added complication of male participation. In one study, two-thirds of lesbians preferred counseling from a female professional (Modrcin and Myers 1990).

Reaching the lesbian intravenous drug users may pose special problems. Case et al. (nd) found that the double stigma of being both lesbians and IVDUs cultivated a highly developed sense of secrecy among the sample. While subjects who considered themselves an active part of the IVDU "street scene" were reached by HIV prevention messages targeted at the general IVDU population, concerns are expressed that subject who identified more with lesbian community or were isolated may not be receiving these prevention messages. A significant number also engaged in sex with men, often for money, and gave birth to children, indicating a significant risk of perinatal transmission. Therefore, information on perinatal HIV risk should be adapted and targeted at this group.

## **5.6 DEALING WITH HIV-RELATED ISSUES**

The problems posed by the threat of HIV infection and its relationship with AOD use has placed further difficulties in the face of prevention and treatment specialists, as well as gay and lesbian therapists in general, as noted above. Because of association of AOD use not only with sexual activity but high HIV-risk sexual activities, AOD treatment professionals increasingly need sexual risk-reduction skills training.

### **5.6.1 Bisexuals**

Different approaches may be required in dealing with bisexual men. As observed, Lewis and Watters' (1990) found that bisexually active men more than heterosexually active men reported exchanging sex for money or drugs but that they self-identified as



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heterosexuals. This raises concerns that these bisexuals may be unresponsive to strategies aimed at self-identified bisexual/gay men.

### 5.6.2 IV Drug Users

Special attention may needs to be directed toward reaching the gay IV drug user in the community and not just in the treatment setting. Treatment centers may not be the best venue to reach gay males at risk. Murphy (1987:390) found that IVDUs *"feel that the clinic-client relationship is an adversarial rather than advocacy relationship"* because of the clinic staff's power, including the power to send them to jail, which strains honest communication. Furthermore, Waters (1987) stresses that as many as half of IVDUs remain out of treatment by choice and not inadequate availability. Watters and Cheng (1987) reported that 6 percent of a sample of intreatment males had histories of homosexual activity within the past five years versus 31 percent of out-of-treatment males. This difference may be an artifact of sampling, but among the out-of-treatment sample, two-thirds had not enrolled in treatment programs in the past five years. This raises the question of how effective a massive extension of treatment services would be and focuses attention on bringing AIDS education efforts to the majority of IVDUs who are not connected to treatment programs.

Murphy (1987) observes that AIDS educational programs that utilize "natural helpers" or leaders in various drug-using communities are more likely to successfully educate their peers. Projects that hire, train, and oversee community health outreach workers (CHOWs), such as the Mid-City Consortium in San Francisco, have been most successful in reaching the hard-to-reach segments of the IVDU population. These natural helpers are able to communicate in the language of the target populations in settings that are nonthreatening. Street education appears to be especially important in dealing with IVDUs. Waters (1987) found strong relationship between access to street-based education and use of effective decontamination among IVDU.



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Education should emphasize that gay IV drug users are simultaneously at dual risk of being infected and of infecting others with HIV. Campaigns need to go beyond health education to attempt to change the ecology of risk for HIV infection by distribution of condoms in drug treatment facilities and areas where needle users congregate, and by distributing bottles of bleach to sterilize works and possibly sterile needles themselves. John Watters, director of a federally funded AIDS-IV drug study in San Francisco, also has found that *"people are most receptive when the hygiene message (e.g., cleaning needles) is not attached to a moral agenda like giving up prostitution or drug use"* (quoted by Murphy 1987:391).

### 5.6.3 The Non-IV Drug User

However, arguably too much attention has been focused simply on the risk of HIV infection from IV drug use and not about the risks posed by the association of AOD abuse and high-risk sexual behavior within the gay community. The differences observed by Stall and Ostrow (1989) between gay intravenous and nonintravenous drug users indicates that different prevention strategies should be used for gay men who use needles and those who do not but combine drug use with sex. It is essential to keep in mind that *"the predominant association of HIV infection with drug use appears to be due to those men who do not use needles, but do combine sexual contact with drug use."* Clear prevention efforts must take nonintravenous as well as intravenous mechanisms for infection into account (Stall and Ostrow 1989:64). Indeed, it seems unlikely that vast numbers of those not already doing so will initiate IVDU and needle sharing in light of AIDS. *"It seems reasonable, therefore, to assume that the principal vector through which AIDS will spread in the general population is unprotected sexual contact with the infected persons"* (Reinarman and Leigh 1987).

Central to the proximal association of AOD use and risky sexual practices, is the widely shared belief that alcohol acts as a sexual disinhibitor (i.e., it leads people to engage in sexual acts in which they might not otherwise engaged). This longstanding belief needs



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to be more fully explored (Reinarman and Leigh 1987). Campaigns directed against this practice also *"may well have the greatest effect if they are designed to convey the idea that combining drugs or alcohol with sex is socially inappropriate during the age of AIDS and is, in any event, less satisfying."* "Server intervention" campaigns might also be undertaken to help stem HIV infection associated with excessive alcohol consumption at bars (p. 71-72).

Ostrow (1986) observes that the links with HIV infection and the "disinhibition hypothesis" suggests several education and intervention actions. First, there should be widespread communication within the gay male community that combining sexual activity and substance use is associated with high risk sexual behavior so that disinhibition is discouraged as an acceptable excuse for risky sexual behavior. Strategies should be developed which minimize the combination of courtship behavior and AOD use, perhaps by establishment of safe places for gay men to meet socially which do not serve alcohol or other drugs. To the extent that there may be underlying personality needs which demand concurrent use of drugs and participation in high risk sexual behavior, this would call for health education efforts to explain the implications of this relationship within the communities at risk, along with community screening and voluntary therapy for those with at-risk personalities. To those who have learned to combine their AOD use with high-risk sex and have found this combination of behaviors difficult to change, it may be advisable to emphasize the adoption of safe sex techniques rather than what may well otherwise be unproblematic AOD consumption. The multifactorial hypothesis indicates that interventions should be comprehensive in nature, and should incorporate the appropriate intervention implications of each of the empirically-supported hypotheses. (See also Ostrow 1987 for a discussion of some of the barriers that have stood in the way of the recognition of this problem.) McCusker et al. (1990) conclude:

*Men who report impaired judgment due to recreational drugs in combination with high-risk sexual practices with multiple partners should be targeted specifically for such interventions, regardless of whether they have been tested for antibody to HIV and their test results. The high self-efficacy among the*



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*subgroup practicing high-risk sexual activity with only one partner in combination with alcohol or drugs but without impaired judgment suggests that these men know their partners well and are confident in their ability to use alcohol or drugs without this affecting their judgment.*

Thus determining the nature of relationships is important for any counseling.

Room (1986) warns, nevertheless, that while knowledge of AIDS may reduce risky behavior for some, it might for others paradoxically strengthen the link between alcohol and sexual disinhibition if drinking is used to suspend this knowledge or excuse unsafe behaviors. Practitioners need to be aware of this as well. Ostrow et al. (1990:764) further advise that *"if the use of recreational drugs is related to the continuance of or relapse to unsafe behaviors, then efforts to 'unlink' sexual and drug-use behaviors might significantly improve AIDS prevention among all adults at risk through sexual activities."* We need to undercut the notion that inebriation excuses behavior (Stall et al. 1986).



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## SECTION 6

### CONCLUSION

Much more needs to be learned about the epidemiology of AOD use within the gay and lesbian communities, and subgroups within them if we hope to develop more effective prevention and intervention programs. Research needs to employ careful sampling strategies, including comparison samples outside of the "magnet" gay ghettos in coastal urban centers, bars, and other convenience samples (Stall and Wiley 1988). We need to use common measures of problems associated with AOD use, quantity of drugs consumed and compulsive use. Ethnographic participant observation studies of the social settings in which use occurs needs to be conducted to help interpret the epidemiological survey data. The unanswered questions far outnumber those for which we have answers. What ethnic, class, or geographically-defined subgroups experience greater AOD-related problems? What are the predictors of problematic AOD use and abuse within these populations? What are the consequences of different patterns of use?

The evidence that is available cautions against making any definitive statement and casts doubt on the assertions that AOD abuse is exceptionally high in this population. At the same time, it substantiates that this is a population at high risk that AOD use will develop into abuse as well as contribute to the risk of developing AIDS. This is a population which clearly needs to be the focus of concerted campaigns to prevent health and social problems associated with recreational use of alcohol and other drugs.

Although there is much that needs to be learned and done to address the prevention and treatment needs of sexual minorities, actions taken by the City of San Francisco have already demonstrated that a rise in service utilization and satisfaction can be achieved. Given the complexity of the etiological influences on AOD use among sexual minorities and



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the diversity of their needs, the most effective programs are those that are most comprehensive. The San Francisco policies which have contributed to higher rates of sexual minorities reported by treatment providers (see Morales and Graves 1983; Vasquez, Frazer, and Stevenson 1989) include financial support of treatment programs for this population, working with mainstream programs to expand the size of their gay/lesbian staff, improving the sensitivity of their heterosexual staff, monitoring programs for evidence of sexual discrimination, conducting outreach efforts, collecting sexual orientation data at intake, tracking the use of services by sexual minorities, and providing services for the partners of recovering gay substance users.

To fully address the needs of the community a comprehensive prevention and treatment program must be undertaken that will first attempt to heighten community consciousness and sense of responsibility regarding the adverse effects of AOD use and so change attitudes, social systems, and behaviors within the communities. Community norms must be influenced by providing alternative outlets for recreation and socialization. This will help to both prevent future problems and maintaining recovery. At the same time, programs must reach out to encourage more AOD-dependent sexual minorities into treatment programs, and that will provide them with effective therapy and support to be function without alcohol or other drugs. It requires creating a supportive environment aimed at building self-esteem, promoting self-actualization, and improving coping skills and competencies. To do so requires an understanding of the diversity of the gay and lesbian communities and the need to tailor prevention and intervention efforts at specific population types and individual lifestyles and characteristics. There are no simple methods or approaches applicable for all gays and lesbians.



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